

# The Canacian Nurse

January 197



university schools of nursing in Canada intravenous hyperalimentation street nurses in blue jeans



# WHITE SISTER - FASHION REPORT "THE INS FOR SPRING"

The look that can shape your image is created in today's many fashion markets. Their designers are numerous, each with their own cult, each with their own attitude, and each with their own influence. You've heard of "Vogue", "Chatelaine", "Harper's Bazaar", but have you heard of "E/Moda", "Linea Italiana", "Freizeit Mode", "Amica", "Pret a Porter". These are just a few of the many top fashion magazines White Sister's designing staff search and interpret every day.

The LAYERED LOOK was introduced this Fall. Its influence grew so strong, it's become **THE IN FOR SPRING**. Many designers have interpreted the layered look through the VEST, the JUMPER, and the exciting CAP SLEEVE.

The new "in" image now being shown by all leading designers is the PINAFORE and the SMOCK LOOK. White Sister's designers have captured these fashion shapes through several one piece dresses, and a new array of pop tops to be worn with pants or skirts and over one piece dresses.

Is the SHIRT DRESS the fashion uniform or the UNIFORM FASHION? That is the question. It's being shown in evening wear, casual wear, career wear and everywhere. New strong imaginative ideas are incorporated into our collection of career wear shirt dresses.

COLOURS ARE SOFT AND HAPPY for Spring and very important, even for the WHITE COLLAR GIRL. Soft pink, blue and lilac take the lead and will be seen in checks, stripes and solids. "THE HAPPY COLOUR ACCENT" will be worn by professional career girls in tops over dresses, skirts, and pants. Some brand new fabrics are being featured in White Sister's "POP TOP ACCENT LINE".

WAIST LINES, some up, some down, some shaped and some straight, some trimmed and some thinned, are strong in the fashion scene again. SKIRTS will be flowing with pleats and soft gathers. Sleeves will be long, short and puffed. Laces and ruffles will be the trimming highlight.

Today's career apparel girl is an attitude, not an age and not just a profession — She wants to look PRETTY, FLUID, CLEAN and RACY, all at the same time — the "INS FOR SPRING", White Sister's latest career apparel line. At your favorite career apparel store... starting in February.

## Lippincott

Further insight for to-day's mirse...



\$ 4.25



NURSING OF PEOPLE WITH CARDIOVASCULAR PROBLEMS

Armington and Creighton

emphasizes an integrated human approach for optimum patient recovery during rehabilitation.

Little, Brown NURSING MANAGEMENT FOR PATIENT CARE

Beyers and Phillips

. . . integrates theory with a pragmatic approach to nursing management problems. flexible cover \$ 4.75 Little, Brown cloth \$ 9.95

NURSING CARE OF THE 3 LONG TERM PATIENT

Blumberg and Drummond .. presents relevant techniques and procedures of eight key concepts in patient management.

Springer PERSONAL, IMPERSONAL AND INTERPERSONAL RELATIONSHIPS

Burton

.. how to recognize the needs of patients; how to listen; how to counsel.

Springer INTENSIVE CARE FOR NURSES

Clark and Barnes

.. demonstrates use of electronic and mechanical equipment with nursing techniques. Blackwell

**DUNCAN'S DICTIONARY FOR NURSES** 

.. covers more than 10,000 terms the R.N. needs to know in nursing, medicine, psychiatry, and the social and biological sciences. Springer flexible cover \$ 5.25 cloth \$ 7.95

MODERN MEDICINE FOR NURSES Gibson

, this new edition has been revised and brought up to date throughout.

Blackwell \$ 8.50 ESSENTIALS OF ABDOMINAL OSTOMY CARE

Honestv

. . describes the care of abdominal stomas in patients who have had colostomy, ilcostomy, cecostomy and urinary diversion operations.

DEVELOPING THE ART OF UNDERSTANDING

. helps see the patient as a person and develop the emotional maturity needed to function in the supportive role.

\$ 5.00 Springer

THE PSYCHOLOGY OF DEATH

Kastenbaum and Aisenberg ... "So well written ... an intelligent reader picking up their book out of mere curiosity might easily read through - and finish the book the beneficiary of a deepening experience." Publishers Weekly.

Springer **RENAL NURSING** 

Uldall

. . . presents detailed instruction in the management of acute and chronic renal failure. Blackwell

**ACUTE CORONARY CARE** 

Whipple et al.

emphasizes physiological, psychological and rehabilitative aspects of patient care. Little, Brown flexible cover \$ 9.95

cloth \$14.95



Serving the health professions in Canada since 1897 J. B. Lippincott Co. of Canada Ltd. 75 Horner Ave. Toronto 18, Ontario

Representing in Canada: Little, Brown and Company Blackwell Scientific Publications Ltd. Springer Publishing Company, Inc.

Please send me the book(s) whose number(s) I have circled						
	1	5	9			
	2	6	10			
	3	7	11			
	4	8	12			
	Name Position					
	Address					
	City Province					
☐ Payment enclosed (send postpaid) Books may be returned within 15 days		Use Char	☐ Use my Chargex number . ☐ Charge and bill me			



# The Canadian Nurse



A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 69, Number 1

January 1973

- 21 Needed: A Change in Attitudes
  Toward Elective Sterilization......L. Fortier
- 23 University Schools of Nursing in Canada
- 34 Street Nurses in Blue Jeans ...... T. Ruiterman, G. Biette

The views expressed in the editorial and various articles are those of the authors and do not necessarily represent the policies or views of the Canadian Nurses' Association.

4	Letters	48	Books
ΙI	News	50	AV Aids
44	Dates	51	Accession List
45	Names	64	Index to Advertisers

Executive Director: Helen K. Mussallem • Editor: Virginia A. Lindabury • Assistant Editors: Liv-Ellen Lockeberg, Dorothy S. Starr • Editorial Assistant: Carol A. Dworkin • Production Assistant: Elizabeth A. Stanton • Circulation Manager: Beryl Darling • Advertising Manager: Georgina Clarke • Subscription Rates: Canada: one year, \$6.00; two years, \$11.00. Foreign: one year, \$6.50; two years, \$12.00. Single copies: .75 cents each. Make cheques or money orders payable to the Canadian Nurses' Association. • Change of Address: Six weeks' notice; the old address as well as the new are necessary, together with registration number in a provincial nurses' association, where applicable. Not responsible for journals lost in mail due to errors in address.

Manuscript Information: "The Canadian Nurse" welcomes unsolicited articles. All manuscripts should be typed, double-spaced, on one side of unruled paper leaving wide margins. Manuscripts are accepted for review for exclusive publication. The editor reserves the right to make the usual editorial changes. Photographs (glossy prints) and graphs and diagrams (drawn in india ink on white paper) are welcomed with such articles. The editor is not committed to publish all articles sent, nor to indicate definite dates of publication.

Postage paid in cash at third class rate MONTREAL, P.Q. Permit No. 10,001. 50 The Driveway, Ottawa, Ontario. K2P 1E2 © Canadian Nurses' Association 1973.

Last month I had to complete a minor business transaction with an elderly gentleman who lives on a farm about 60 miles from Ottawa.

I found the farm without difficulty, "Just look for the house behind the white picket fence and gate," his wife had said when I talked to her on the telephone earlier that day.

Two kittens playing on the veranda showed as much difference in their behavior as two persons might: one fled, so I saw only a disappearing tail; the other meowed and curled herself around my snowboots, waiting to be picked up.

The couple welcomed me, and I sat down at the kitchen table to give the man the information he required to transact our business. After, the woman, who had been busy putting trays of pastries into the oven of the kitchen range, brought me a cup of coffee, some freshly-baked cookies, and a piece of gumdrop cake. The three of us sat at the table and at first talked about things that strangers generally talk about: the weather, the local elections, and so on.

Then I learned the couple had raised four girls and a boy, who now lived elsewhere, although not too far away. "One of our girls is an RN, and now her daughter is in nursing," the woman said proudly. "As it turned out, the couple's daughter and I shared the same alma mater, so we spent some time discussing that school, the changes in nursing education, and change in general.

Things do change rapidly, we agreed, and each person has to adjust. And, the woman said, it really doesn't matter what changes as long as our basic values remain the same. "It's what's right here inside us that's important," she added.

Sitting with this couple, sharing the warmth of their kitchen and their company, I realized their philosophy — although not new — is often forgotten by those of us who live and work in the competitive, hectic, sometimes impersonal, cities in our society.

It really is "what's right here inside us" that's important.

— Virginia A. Lindabury.

# letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

#### Questions author

I read with interest the article by Dr. V. Rudnick, "I Hate Nurses!" in the November 1972 issue of *The Can*adian Nurse. I could not help but wonder how nurses would respond to the statement that "the nurses are considered primary care physicians and serve as such."

Perhaps someone should ask Dr. Rudnick how he would feel about an article in the Canadian Medical Association Journal by a nurse stating that "the doctors are considered primary care nurses and serve as such.'

In a more serious vein, I suggest that the problem nurses are facing is similar to that being worked through by general practitioners in their relationship to specialists. There is a great deal to be said for being defensive and blaming "them" for the position in which we find ourselves. Certainly the experience some of us have had over the past five years in shifting from general practitioners to family physicians has provided a certain degree of awareness of the difficulty in changing — even though the goals are highly desirable.

I am certain my colleague Vince Rudnick will come back with some response. And who knows, there may be some advantage in having physicians "contaminating" the pages of your journal — R.G. McAuley, M.D., C.C.F.P., Associate Professor, Dept., of Family Medicine, McMaster Uni-

versity, Hamilton, Ontario.

Author replies

I am flattered to receive Dr. R.G. Mc-Auley's response to my opinion in the November 1972 issue of The Canadian Nurse. My friend and colleague speaks with tongue in cheek, as I did, concerning the "primary care physician" nurse.

My article pointed out the void between present-day nursing and the medical profession as far as service is concerned, and I tried to stimulate the nurse to accept this responsibility. At the same time, I pleaded with both the public and the medical profession to let the nurse fill this gap. I prefer to call this health professional the "nurse" and not the "primary care physician." But sometimes it is good to use terms with tongue in cheek — to stimulate, as I believe it did this time.

As far as Dr. McAuley's second point is concerned. I see no similarity in the relationship between general practitioners and specialits and the problems nurses are facing. I do see problems between the present-day nurse and the type of nurse I envisage as developing. However, I tried to prevent this by asking the nursing schools to consider the ambulatory field more and to train all nurses through this area. If the hospitalization rate of patients in ambulatory settings is less than 0.1 percent, why train nurses only in hospital settings?

I agree that fragmentation of care, medical or nursing, does lead to specialist evolution, but this was not my point. My point was to exhort the nurse to accept the role I described, to encourage the medical profession to allow her (him) to fill this role, and to get the layman to accept the nurse in

her new expanded role.

As to "contaminating" the pages of The Canadian Nurse, perhaps it is time we did break out of our union boundaries and explore problems common to both professions. — K.V. Rudnick, M.D., Director, Primary Care Unit, McMaster University Medical Centre, Hamilton, Ontario.

Article refreshing

Thank you for the article "I Hate Nurses!" by Dr. K.V. Rudnick (Nov. 1972). It was refreshing and oh, so true. I know I have a brain, but I have often wondered when I get a chance to use it in nursing. Too often I end up getting a bewildered look, a frown, and even a rebuke.

We nurses have too many things not going for us. How often do we sit down at coffee or lunch for a bitch session, but never look for solutions? How many cowards are there among us? If we can't even stand up for basic rights, how can we stand up for the important ones?

#### Letters Welcome

Letters to the editor are welcome. Because of space limitation, writers are asked to restrict their letters to a maximum of 350 words.

Too often we come up against the hypocrisy of the system. Whose idea is it that a cap is all-important for the nurse's image? Surely our professionalism comes across in our demeanor and actions, rather than in small observances, such as wearing a cap.

Recently, a colleague told me I looked like a member of the housekeeping staff without my cap. Actually, this comes close to the truth, for half our nursing "duties" consist of simple housework our mothers taught us when we were young. We spend three years learning skills we seldom use.

Dr. Rudnick says he hates nurses. Well, I have come close to hating doctors. There have been many times when a question has not passed my lips because the medical staff would have belittled it, or me, as a result.

How can we, as nurses, stick up for ourselves unless we stick together? Too often we are ruled by intimidation and become submissive. We tend to be too passive in a role that Florence Nightingale fought to make better. Surely we can follow her lead and forge ahead to meet new goals. — M.V. MacDonald, R.N., Toronto, Ontario.

Article in wrong journal

The editorial staff is to be congratulated for providing its readers with the timely article "I Hate Nurses!" by Dr. K.V. Rudnick.

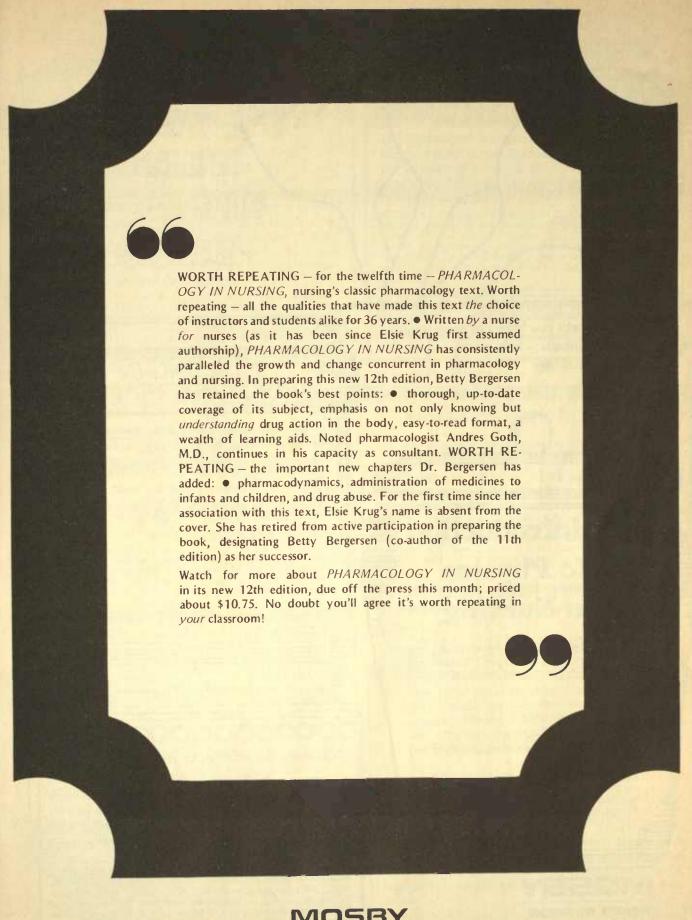
The publication of this article in The Canadian Nurse suggests that once again nurses need doctors to speak for them. It also suggests that nurses are in no position to evaluate critically their existing status or initiate and implement changes regarding their perceived role on the health team.

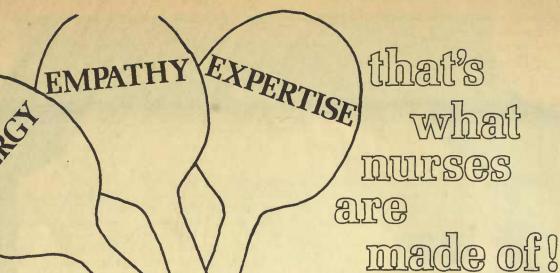
Dr. Rudnick's views have long been recognized by many in the nursing profession, and steps have been taken to assist nursing students to examine the changing role of the nurse. In doing so, the greatest resistance continues to come from physicians. For this reason, I believe his article should have appeared in a medical journal, not in The Canadian Nurse.

If the author of this article had been a nurse, I wonder whether he would have felt free to submit it for publication? Would The Canadian Nurse

(Continued on page 8)

JANUARY 1973





RECIPE X

Mosby texts help you bring out these qualities in today's students - help prepare them for tomorrow's challenge.

New 6th Edition!

Flitte

# **An Introduction** To Physics In Nursing

Simplified discussions focus on essential physics concepts as they apply to nursing. Students will learn to apply these concepts to patient care, therapeutic procedures, and currently used equipment. A new introductory discussion explores the nature of science, scientific inquiry, and scientific theory - information your students will value throughout their education and career.

> By HESSEL HOWARD FLITTER, R.N., Ed.D., Director, Division of Allied Health and Professor, Ohlone College. April, 1972. 6th edition, 273 pages plus FM I-XII, 714" x 101/2", 158 illustrations. Price, \$7.10.

TIMES MIRROR

THE C.V MOSBY COMPANY LTD 86 NORTHLINE ROAD TORONTO 374, ONTARIO, CANADA

A New Book! entropy of the contract of the

Fagin

#### NURSING IN CHILD PSYCHIATRY

Unfortunately, many nurses begin their careers with limited knowledge of child psychiatric problems. Now, a new text stresses the difference between child and adult needs. With emphasis on the role of nursing intervention, discussions explore introductory concepts of child psychiatry, the problems of latencyaged children, racism, the family as a unit of treatment, and much more!

Edited by CLAIRE M. FAGIN, R.N., Ph.D., Professor and Chairman, Department of Nursing, Herbert H. Lehman College, The City University of New York, Bronx, N.Y.; with 7 contributors. June, 1972. 183 pages plus FM I-XIV, 6" x 9". Price, \$6.05.

A New Book!

Barnard-Powell

#### 0000000000000

TEACHING THE MENTALLY RETARDED CHILD

A Family Care Approach

The families of retarded children often require as much help as the children, themselves. This new text presents students with background information on how to meet the abnormal child's needs, as well as methods for helping families learn to cope.

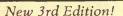
By KATHRYN E, BARNARD, R.N., B.S.N., M.S.N., Ph.D., Professor of Nursing; and MARCENE L. POWELL, R.N., B.S.N., M.N., Assistant Professor; both of University of Washington School of Nursing, and associated with Child Development and Mental Retardation Center, University of Washington, Seattle, August, 1972, 158 pages plus FM 1-XII, 6" x 9", 15 illustrations. Price, \$4.75.

Latham-Heckel

## PEDIATRIC NURSING

This new edition shows students how an understanding of psychological factors can lead to improved care for young patients. Nine comprehensive chapters are devoted to pediatric nursing techniques, each chapter focusing on a different childhood disorder. Throughout the text, your students will find helpful information on nutrition and diet therapy.

By HELEN C. LATHAM, R.N., M.L., M.S., Associate Professor of Nursing, School of Nursing, Louisiana State University, New Orleans, La.; and ROBERT V. HECKEL, B.S., M.S., Ph.D., Professor of Psychology, University of South Carolina, Columbia, S. C.; with the collaboration of JOYCE A. VERMEERSCH, B.S., M.P.H. April, 1972. 2nd edition, 490 pages plus FM I-XIV, 7"x 10", 183 illustrations and 2 color plates, Price, \$10.25.



Matheney et al.

#### 

**FUNDAMENTALS OF** 

#### PATIENT-CENTERED NURSING

This significant text describes the application of nursing fundamentals to patients' basic physical and psychological needs, their immediate health problems, and long-term rehabilitative care. The patient-centered approach emphasizes general principles rather than specific techniques and teaches students how to cope with emotion-laden situations.

By RUTH V. MATHENEY, R.N., Ed.D., Professor, Department of Nursing, Borough of Manhattan Community College of the City University of New York, N. Y.; BREDA T. NOLAN, R.N., M.A., M.Ed., Professor, Department of Nursing, Nassau Community College, Garden City, N. Y.; ALICE E. HOGAN, R.N., M.S., Professor, Department of Nursing, Bronx Community College of the City University of New York, Bronx, N. Y.; and GERALD J. GRIFFIN, R.N., Ed.D., Director, Department of Associate Degree Programs, National League for Nursing, New York, N. Y. May, 1972. 3rd edition, 288 pages plus FM I-VIII, 7"x 10", 95 illustrations. Price, \$8.70.

#### 

#### MOSBY

TIMES MIRROR

THE C.V. MOSBY COMPANY LTO 86 NORTHLINE ROAD TORONTO 374, ONTARIO, CANADA Instructors note: To receive a complimentary copy for firsthand evaluation, write to the Textbook Department, mentioning your position, course, and enrollment.

#### THE NURSE'S ROLE IN COMMUNITY

#### MENTAL HEALTH CENTERS

#### 

#### Out of Uniform and Into Trouble

This provocative text records how other disciplines view and react to the psychiatric nurse. By reading the impressions of psychiatrists, social workers, etc., your students will achieve a more objective approach to their nursing duties.

By CAROL D. DeYOUNG, R.N., M.S., Associate Director of Nursing, Tri-County District Health Department, Englewood, Colo.; and MARGENE TOWER, R.N., M.S., Director of Psychiatric Nursing, Community Mental Health Center, Denver General Hospital, Denver, Colo.; with 5 contributing authors. 1971, 117 pages plus FM I-XVIII, 6½" x 9½". Price, \$5.15.

New 10th Edition!

Smith

#### MICROBIOLOGY AND PATHOLOGY

This new edition provides students with a solid foundation in these basic medical disciplines. It clearly relates microbiology to infection and disease, with increased emphasis on cocci, bacilli, spirochetes, and viruses.

By ALICE LORRAINE SMITH, A.B., M.D., F.C.A.P., F.A.C.P., Associate Professor of Pathology, University of Texas Southwestern Medical School, Dallas, Tex.; Assistant Professor of Microbiology, Department of Nursing, Dominican College and St. Joseph's Hospital, Houston, Tex. June, 1972. 10th edition, 668 pages plus FM I-XII, 8" x 10", 457 illustrations including 2 color plates. Price, \$12.90.

\_ A New Book!

Weldy

# Body Fluids And Electrolytes

#### A PROGRAMMED PRESENTATION

If a programmed approach makes learning easier for your students, they'll welcome this new book. It discusses such topics as: the role of kidney and endocrine systems in maintaining homeostasis; causes of fluid shifts; alteration of body content; and the various methods by which transport is accomplished. Clinical examples of various imbalances are described in each section.

By NORMA JEAN WELDY, R.N., B.S., M.S., Assistant Professor of Nursing, Goshen College, Goshen, Ind. June, 1972. 101 pages plus FM I-XII, 7" x 10", 24 illustrations. Price, \$4.15.

#### letters

(Continued from page 4)

editorial staff have published the article? — Cathryn L. Glandville, Associate Professor, School of Nursing, McMaster University, Hamilton, Ont.

Yes, we'd have published it.

- Editor.

#### Mothers need home care program

It was with great interest that I read the article "And most important of all, she loved him" by Margaret Pandya (October 1972). I have a child in day care and have found that we working mothers have a great need for a home care program, such as the one outlined in this article.

A group of mothers from our Day Care Society is to design a program to meet our needs. We are most anxious to plan and put into effect a home care plan for two reasons. First, winter is now upon us, bringing colds and so on, not to mention childhood diseases. Second, the Local Initiatives Program deadline was December 31, 1972, and the grants will be considerably smaller than last year. — D. Victoria Orchard, public health nurse, Northern Interior Health Unit, Prince George, British Columbia.

Anyone who would like further information about the home care service program described in Ms. Pandya's article can write to Margaret Blair, clo The Protestant Children's Village, 983 Carling Ave., Ottawa, Ontario K1Y 4E5.— Editor.

#### Grad of '47 for women's lib

Who would ever have thought that I, a graduate of the class of '47, would take up the banner of women's lib? It is so amazing that I must tell my story.

Recently I applied for my registration in Alberta and found that one of the documents I had to send to that august body was my marriage license (the same routine applies in British Columbia, too)! As my husband is a professional engineer who also belongs to a professional group, I asked him if he had to send our marriage license when he applied for registration in the various provinces we have lived in. "Heavens no. What has a marriage license got to do with my work?" he replied.

What has a marriage license got to do with the Registered Nurses' Association of Alberta or with any other provincial association? Why can't they accept my word that I am married? What concern can it be to them if I am "shacking up" or not? Marriage has not improved my nursing ability. Perhaps it has given me a more patient nature than I had 26 years ago. Who knows? — G.E. Ryan, Edmonton. Alberta.

As we made an error in the following letter that appeared in the November 1972 issue, we decided to reprint the letter in toto:

Challenges author

As a practicing public health school nurse, I cannot refrain from challenging Ms. Garrett about her article, "Choosing contraceptives according to need," in the September issue of the journal,

for which I pay too much.

The author must be aware of the legal complications involved in counseling a minor (implied by her words "young teenager"). The legal age of consent — 18 and over — precludes the nurse from teaching contraception to young females. Let us not forget young males. Canadian social and legal reform is the focus here, not the nurse's refusal to become involved. Many in our society are ambivalent about this subject and how it should be taught.

Contraception, sexual responsibility, and sexuality are taught in several high schools to students who have parental consent. These topics are incorporated in health classes and are one component of a broader subject—the family in society. I teach those students with consent of both parent and

school.

A health complaint need not be the prerequisite for sexual discussion, only a desirous student. The nurse cannot teach the effective use of condoms should they be mechanically dispensed. One wonders how many adolescents would be emotionally and psychologically prepared to face the tirade of comments from their peers should they be discovered purchasing a prophylactic. The author's suggestion seems akin

#### NOTICE

ICN advises there will be no extension of the final registration date of Feb. 28, 1973.

Members wishing to attend the ICN Congress must mail completed application forms to CNA before Feb. 14, and must enclose the \$55 registration fee. Personal checks must be made payable to CNA. If fees are made payable to the ICN Congress, use bank money orders in U.S. funds.

to placing an individual in a cockpit and telling him to fly solo!

Thousands of patients are seen yearly by Kinsey, Masters and Johnson, and at the Prague Sexological Institute. Of interest is a recent finding that sexually active young adolescent girls — as yet few in number — later complain of dyspareunia of psychological origin caused by their previous sexual history. The breakdown of marriages due to sexual inadequacy alarms me.

Those who help couples on sexual matters would be wiser to use a text written by professionals with years of sexual counseling experience. Two such books are *Human Sexual Response* and *Human Sexual Inadequacy*, by Masters and Johnson. They suggest activities to increase responsiveness. To prevent sexual problems, a Canadian sexology institute comparable to that described by these authors is imperative.

I agree that abortion for some is a necessity. But how long can we wait for the necessary reforms to counsel all men and women of reproductive age who desire contraceptive advice? To legislate positively does not mean that we are condening outright promiscuity within the nation; nor do I think this will occur — V. Webb, RN, PHN, Ottawa, Ontario.

Physician looks at team concept

During a discussion with an engineering friend who works for a large company, we decided he works in a vertical system and I work in a horizontal one. That is, he is responsible to his superiors, and has people responsible to him; by contrast, I work with my peers. This left me with a warm glow of self-satisfaction, democracy, and so on, until the next day.

Reconsidering the medical situation, I decided I really didn't work in such a horizontal system after all. Indeed, the care of the ill is a stratified business. Maybe I did not think so initially because I do not hire or fire people, or make or break careers. However, my so-called orders are supposed to be

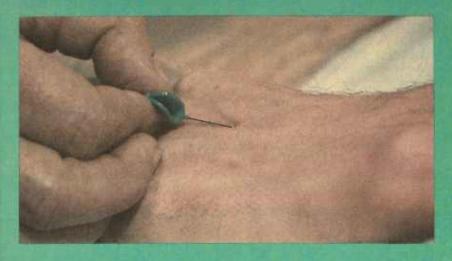
carried out.

Now I am aware that the nursing profession has for some years been promoting the team concept. Perhaps this is why I thought I worked in a horizontal system. The name of the game is to score a goal (to help the sick patient); who fires the shot couldn't matter less, as long as it is done. Fine. Everyone has his eye on the goal and loses himself in the game. We can even wear the same uniform and do away with titles.

Does this assume, however, we can

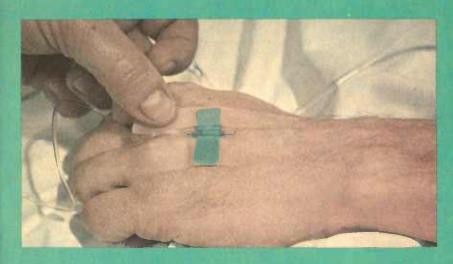
(Continued on page 10)

# We've put a handle on VENIPUNCTURE...



Just hold the Butterfly Infusion Set by its "wings" and you're ready for venipuncture. The wings fold upward easily to serve as a needle holder. They give you a firm, sure grip: all the "handle" you need for accurate manipulation and easy penetration of tissue and vein wall.

## ...and an anchor on SECURITY



Start your next I.V. procedure with a Butterfly Infusion Set

Ultrasharp needle has a short-bevel point for easy entry . . . thinwall construction that allows for increased flow without increasing outside needle diameter. Slim, hub-less design and soft, flexible tubing for easier handling. There's a size for almost every infusion need. Ask your Abbott Representative to show you our entire collection.

Simply release the Butterfly wings after venipuncture. They fold back from their "uptight" position and lie flat against the patient's skin. Flat, but firm—a secure anchor surface. Just tape them down and the needle is completely immobilized.

Large-bore Butterfly-14 and 16 for surgery or hemodialysis

Medium-gange Butterfly-19 and Butterfly-21 for general-purpose infusions

Special Butterfly-19, INT and Butterfly-21 INT with reseal cap for intermittent I.V. therapy

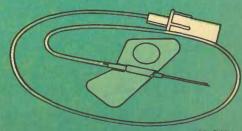
Small-gauge Butterfly-23 and Butterfly-25 for pediatric/geriatric use

Short cannula Butterfly Short-25 for scalp vein infusions

# **BUTTERFLY' INFUSION SET**



The Venipuncture Specialists—
Quality I.V. equipment to meet every need



#### letters

(Continued from page 8)

all skate equally fast, and shoot with equal accuracy? Does this assume we have all had equal training camps and have polished our skills equally?

Surely, if we are playing all out, the uniforms will just be a blur of color, except for the slow skater who is still at the other end of the rink. That team member is slow, no matter what his position.

I know there are slow doctors. To paraphrase an American saying: all of them are open to criticism some of the time, and some of them all the time. Perhaps this applies to other team members as well. On occasion it has been noted that the inept R.N. is jealous of her rank vis-à-vis the praetical nurse (especially if the practical is a fast skater). Variations of this theme may be played for all team members.

Then there's the danger of the team

becoming bureaueratic. It seems to me the poorer skaters are attracted to this field, where they get to tell the good skaters how to skate. If they have been away from the ice long enough, they may even get to redesign the game and the arena. Every position on the team has this problem.

So what can we do about it? Is it naive to concentrate just on skating, passing, and shooting, and if players can't cut the mustard, bench them? (Certainly don't promote them.) Perhaps then we would have a true lateral system, or team. — Frank T. Murdoch, M.D., Kamloops, British Columbia.

# **Hollister's complete** svstem

#### regular and 24-hour collectors in newborn and pediatric sizes

#### get any intant urine specimen when you want it

The sure way to collect pediatric urine specimens easily . . . every time . . . Hollister's popular U-Bag now has become a complete system. Now, for the first time, a U-Bag style is available for 24-hour as well as regular specimen collection, and both styles now come in two sizes . . . the familiar pediatric size and a new smaller size designed for the tiny contours of the newborn baby.

Each U-Bag offers these unique benefits: - doublechamber and no-flowback valves ■ a perfect fit on boy or girl, newborn or pediatric protection of the specimen against fecal contamination | hypo-allergenic adhesive to hold the U-Bag firmly and comfortably in place without tapes ■ complete disposability.

Now the U-Bag system can help you to get any infant urine specimen when you want it. Write on hospital or professional letterhead for samples and information about the new U-Bag system.

HOLLISTER LIMITED . 332 CONSUMERS RD., WILLOWDALE, ONT.

Dorothy M. Percy scholarship fund

Members of the Ontario committee of the Dorothy M. Percy scholarship fund have appreciated the generous contributions made by nurses to this fund in the past. Dr. Percy, who was chief nursing consultant for 20 years with the department of national health and welfare, was awarded an honorary doctor of nursing degree by the University of Ottawa in 1967.

The \$250 scholarship is awarded to a student enrolled in the school of nursing at the University of Toronto. Candidates must be experienced registered nurses with demonstrated leadership potential or demonstrated ability in one of the specialties, and must be in a degree program with the intention of entering the service field.

In 1972, the Dorothy M. Percy scholarship was awarded to Patricia A. Guenther, a third-year postbasic student.

Contributions for this scholarship fund may be sent to: Patrick Phillips, Director of Student Awards, Simcoe Hall, University of Toronto, Toronto, Ontario. Cheques can be made payable to the University of Toronto and marked for the "Dorothy M. Percy Scholar-ship Fund." For income tax purposes, receipts will be issued for any sum over \$5. — G. Vivian Adair, Ottawa, Ont.

Obsolete system

Regarding your article in the June 1972 issue, "Needed: a school-based health center for children": I believe this is an obsolete system and overlooks the family, the elderly, the TB patient, and prenatal or postnatal services.

It would be impossible to amalgamate the public health services with the total health care team as centered in the hospital. Finally, the school-age child receives a large portion of public health monies in services relative to his state of health. He is in the healthiest age group. - E.J. Erion, public health nurse, Sudbury, Ontario.

### news

The Canadian Nurse One Of Six Nursing Journals Indexed

Ottawa — The Canadian Nurse is one of six English-language nursing journals covered by MEDLINE, the computerized, bibliographic search service that replaces MEDLARS for the USA. MED-LARS, which covers over 200 nursing journals, will continue to be available in Canada. (See "MEDLARS and you," January 1971, pages 46-7.)

The six nursing journals selected for MEDLINE include The American Journal of Nursing, Nursing Outlook, Nursing Clinics of North America, Nursing Research, and Nursing Forum, in addi-

tion to The Canadian Nurse.

The Canadian English-language nursing journal is also included in 10 nursing magazines covered by Index Medicus. L'infirmière canadienne, the Canadian Nurses' Association's Frenchlanguage journal, is also picked up by several indexes.

The inclusion of The Canadian Nurse in the "prestige group" of nursing journals was reported by Margaret Parkin, CNA librarian, after a recent meeting of the International Nursing Index advisory committee in New York City. Ms. Parkin represents Dr. Helen Mussallem, CNA executive director, on the advisory committee.

There were 134 Canadian subscriptions to the International Nursing Index (1N1) in 1972, compared to 138 in 1971. "It is disappointing that Canadian subscriptions are down," Ms. Parkin said. "INI is particularly helpful as it is the only nursing index that covers French language material. It is disappointing to note, too, that only 59 schools of nursing in Canada subscribe to the INI.

The International Nursing Index uses the U.S. National Library of Medicine's computer facilities to provide references on nursing subjects from approximately 200 nursing periodicals published around the world, and over

2,300 nonnursing periodicals.

Published quarterly, INI cumulates with each new issue for the calendar year. The fourth issue each year includes all references for the year plus lists of books on nursing published during the year, lists of national and international nursing associations' publications, and lists of all doctoral dissertations prepared by nurses.



His Excellency, the Rt. Hon. Roland Michener, Governor General, with Dr. Helen K. Mussallem, executive director of the Canadian Nurses' Association. The Governor General, known to be a keen supporter of physical fitness, officially opened the National Conference on Fitness and Health, held at the Government Conference Center in Ottawa December 4-6, 1972. His comment that he had been accused of "jogging in Mr. Stanfield's underwear" brought the house down.

Inquiries about subscriptions should be sent to: International Nursing Index, 10 Columbus Circle, New York, N.Y. 10019, USA.

Physical Fitness Of Children Leaves Much To Be Desired **Physician Tells Audience** 

Ottawa — For the ordinary Canadian child, physical fitness seems to decrease rapidly as he ages, a Saskatchewan physician told delegates at the National Conference on Fitness and Health, held December 4-6, 1972.

Speaking about exercise and its effect on growth, Dr. Donald Bailey, professor of physical education at the University of Saskatchewan, said schools have failed in their attempt to help keep children physically fit. "The time allocation to physical education in Canadian schools ranks among the lowest in the world," he said. In contrast, schools in countries such as Japan, East and West Germany, and Poland provide at least four 40-minute periods of physical education from elementary school right through high school, he added.

Dr. Bailey said if the present school curricula and children's attitude to physical fitness are to change, mothers must become convinced, as they are the most influential change agents. He agreed with the recommendation made by the Royal Commission on the Status of Women, that girls should be encouraged to participate in sports.

The conference, sponsored by the department of national health and welfare, was attended by physical educators, recreation and parks directors, government planners, and physicians, invited as delegates. Few nurses were invited. The planning committee for

**Next Month** 

# Canadian Nurse

- Acupuncture
- Trace Elements in Man
- Coronary Patients and Their Families Receive Incomplete Care
- VON Senior Citizens' Housing Program



Photo credits for January 1973

Photo Features, Ottawa, p. 11

Jack Lindsay Ltd., Vancouver, p.35

St. Joseph's Hospital. Toronto, pp.39-41,43

Ranson, Edmonton, Alta., p.45

Metropolitan Life, Ottawa, p.50

#### news

(Continued from page 11)

the conference, chosen by the DNHW, included representatives from many organizations. The Canadian Nurses' Association was not invited to be a member of the planning committee.

#### SRNA Exec. Secretary Summonsed **Before Labor Relations Board**

Regina, Sask. — Alice Mills, executive secretary of the Saskatchewan Registered Nurses' Association, was summonsed by the Service Employees' International Union (SEIU) to appear before a labor relations board hearing December 6, 1972, in Regina. Earlier hearings of the board, called for October 3 and November 7, were

postponed.

Three applications before the fiveman board related to nurses in Nipawin. The first was an SEIU application to represent all employees, including three registered nurses, at Pineview Lodge nursing home; the nurses opposed this application. The second was by Nipawin District Staff Nurses' Association to represent the nurses at Pineview Lodge, and the third was by the same nurses' association to represent the nurses at the Nipawin Union Hospital.

The union summons to Ms. Mills, which arose from the second and third applications, requested her to produce SRNA documents, dating to 1965, concerning the association's membership, elected council, policy on labor relations, formation of staff nurses' associations, and collective bargaining.

The key, Ms. Mills told The Canadian Nurse, is the union's allegation that SRNA is a management-dominated organization that is controlling collective bargaining. She called this a test case — the first time that nurses in the province, who work in a nursing home or hospital, have been included in this kind of union.

R.L. Barelay, counsel for the Nipawin nurses' association, said at the October 3 hearing that SEIU was challenging the Nipawin association's applications on the basis that the association was organized and assisted with SRNA's help, and that SRNA was company-dominated.

Mr. Barclay said SRNA was not a company-dominated organization as defined by the Trade Union Act, and was not a party to any of the applications before the board. He called the

Nipawin association a separate association, having a constitution different from the SRNA and in no way connected with that association. He also told the labor relations board that SRNA was not an employer or an employer's agent in relation to the matters before the board.

The board's decision, which was expected to be known before the end of December, will be reported in a later issue of The Canadian Nurse,

**Ontario RNs Attend Workshop** To Improve Long-Term Care

Toronto, Ont. - Twenty registered nurses from the Toronto area, all employed in nursing and old-age homes, took part in a three-week pilot workshop that began November 2, 1972, at the office of the Registered Nurses' Association of Ontario. RNAO paid all the costs of the workshop.

This program was designed to refine the nursing and supervisory skills of the RNs, who are responsible for teaching, directing, and supervising the nursing care given by other personnel in nursing homes and homes

for the aged.

Three concerns the nurses shared were the need for better continuity of care between nursing and old-age homes and other health agencies in the community; the problem of handling the higher percentage of serious medical problems that patients in these homes now have; and the belief that the financing of the homes is inadequate to provide the quality of care the nurses believe should be given.

Objectives of the workshop included helping the nurses develop skill in assessing residents' nursing needs for physical, emotional, social, and recreational care; recognizing the needs of family members that relate to the care of the resident; interviewing the resident and/or his family to complete the nursing history; constructing a nursing care plan based on individual needs and

#### Jeanne Mance Stamp In April

Ottawa—A Canadian postage stamp honoring Jeanne Mance will be issued on 18 April 1973, according to the philatelic branch of the Canadian Post Office. The year 1973 marks the 300th anniversary of the death of Canada's most famous nurse of early history.

The stamp was proposed by the Comité Histoire of Hôtel-Dieu de Montréal Hospital, and supported by the Canadian Nurses' Association

and individual nurses.

sound nursing principles; and working with nursing and non-nursing staff in discussion groups to make nursing

decisions.

Three Ontario government departments, the Ontario Association of Homes for the Aged, Ontario Nursing Homes' Association, Ontario Hospital Association, and RNs employed in long-term care helped plan the program.

**RNABC Board Meetings** Now Open To Observers

Vancouver, B.C. — A new policy, established by the board of directors of the Registered Nurses' Association of British Columbia at its November 1972 meeting, means that six observers will be allowed to attend future meetings of the board.

At future board meetings, six seats will be allocated, on a first-come, firstserved basis, to members of the RNABC or to the Student Nurses' Association of

British Columbia.

In other business, the board of directors deferred consideration of a recommendation from the committee on mandatory registration for lay participation on the board or on the committees on registration and nursing education. Lay participation on the board would require a change in the Registered Nurses' Act.

It was decided that before the board meets in January, the report of the committee on mandatory registration would be distributed to chapters and metropolitan districts for discussion of this proposal and for feedback of

membership opinion.

The RNABC board approved a second recommendation from the committee that the association not press for mandatory registration in the province. In its report, the committee advocated investigating the feasibility of mandatory continuing education, but it did not make a formal recommendation on this.

**Professional Midwives Can Care** For Majority Of All Deliveries

Washington, D.C. — Professional midwives can take care of most deliveries. This is the opinion of Dr. G.J. Kloosterman, chairman and professor, department of obstetrics and gynecology, University of Amsterdam, Holland.

Dr. Kloosterman spoke at the 50th anniversary meeting of the International Confederation of Midwives (ICM), attended by over 2,000 persons from 96 nations in Washington, D.C., Oct. 28 to Nov. 3, 1972.

He stated that the first task of the midwife is to protect the completely

healthy woman against "unnecessary interference, impatience, over estimation of technology, and against human meddlesomeness. This holds true for the midwife working in poor countries . but it is also true for midwives in affluent societies.

Dr. Louis M. Hellman, deputy assistant secretary for population affairs, U.S. department of health, education, and welfare, said: "Midwives are responsible for a major portion of the world's maternity care. In the developed world, where regulation of midwifery is strict and standards of training are high, a majority of the deliveries continue to be performed by midwives.'

A change in the constitution adding family planning to the objectives of the ICM was approved by representatives of the 40 national midwives' associations that are members of the ICM.

Rosemary Perkes, principal midwife officer, Belfast, Ireland, said "midwives . . . have found it difficult to feel involved in family planning, but slowly they are realizing that theirs is a unique position in terms of the confidence of the patient, and that these matters can be discussed naturally and unhurriedly while visiting in the patient's own home during the puerperium."

Midwives and nurse-midwives "are perhaps the most staunch supporters of family planning because of the improvement we can see in the health and wellbeing of those mothers... who are practicing some form of family planning." This is the observation of Elaine Pendleton, certified nurse-midwife, family planning program, Downstate Medical Center, Brooklyn, N.Y. "We who believe so firmly in providing family-centered care must realize that it cannot be complete without including instruction in methods of family planning.'

At the recent meeting, voting delegates to the ICM accepted a new definition of the midwife: A midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice

midwifery.

"The new definition of the midwife is flexible enough for countries without recognized midwifery practice and educational programs, and will still be a guideline for countries that have organized programs," Catherine Keith, medical services branch, department of national health and welfare, told The Canadian Nurse.

Canadian nurses and nurse-midwives attending the ICM meeting included: Brenda Wrott, Pat Hayes, and Violet



#### news

Matheson, U. of Alberta school of nursing faculty; May Toth, McMaster faculty; Eileen Hoy, Chatham, Ont.; Ruth May and Joyce Owers, Dalhousie U faculty; Helen Perry, U. of Toronto faculty; Elaine Carty, Queen's U. faculty; Lucie Couillard, Denise Beaulieu, and Ms. Keith, medical services, department of national health and welfare; Mildred Morris, U. of Ottawa faculty member who is studying obstetrical nursing-midwifery at Yale U; and Dolores Laliberté, Montreal, who is a student at Johns Hopkins U.

**Latin American Nurses Consider** Middle Level Nursing Education

Ottawa - Nurses representing Latin American countries met to examine the need to introduce intermediate level nursing programs in those countries of Central and South America that do not have them. They also considered alternatives to the middle nursing level in meeting nursing and health goals, during a two-week seminar held in Caracas, Venezuela, November 13 to 24, 1972.

Helen K. Mussallem, executive director of the Canadian Nurses' Association, was one of two short-term consultants invited by the Pan American Health Organization (PAHO) to assist

participants at the seminar.

Most countries of Middle and South America have only two levels of nursing personnel: professional nurses, who are graduates of university nursing programs, and nursing auxiliaries. Most of the direct patient care is given by auxiliary nurses; the universityeducated nurses are in administrative positions. There are proportionately more university-prepared nurses in some Latin American countries than

Dr. Mussallem told The Canadian Nurse the interactions among the more than 30 seminar participants were "the most interesting, dynamic group process I've ever participated in. The discussions, conducted in Spanish,

were very intensive.

The variety of techniques used by the group and the strength of the group process facilitated production of a change in the nurses' attitudes toward ideas that had seemed impractical, she said.

Dr. Mussallem was invited to be a consultant in planning and presenting the seminar because of her studies on nursing education in Canada and because of changes in Canadian nursing education.

Nursing education in most of the Latin American countries is under the ministry of education. Although there is wide variation among the countries of Central and South America in their educational systems, the nearest Canadian equivalent to their national schools of nursing at the intermediate level is a Canadian diploma program in an educational institution.

A seven-member technical advisory committee on nursing called by PAHO/ WHO in November 1968 said in its report: "Most nursing care [in Latin America] is provided by auxiliary personnel whose general educational background and knowledge of nursing is very limited and who are required to perform duties beyond their competence. Consequently, in the health services a great many nursing duties are not performed or are performed only in part because of the shortage of nurses and the low level of training of auxiliaries.'

The report of the first meeting of the technical advisory committee on nursing, of which Dr. Mussallem was chairman, recommended that PAHO encourage the countries of the region to establish and develop three levels of nursing personnel. The report defined the intermediate level of nurses as the group who "will provide patients or communities with most of their direct nursing care."

This was the intermediate level of nursing discussed at the 1972 seminar. Evaluating the Caracas seminar, the participants, in general, found it helpful. Dr. Mussallem told The Canadian Nurse she was impressed by the youth, poise, and intelligence of many of the senior nurses selected by their governments to participate in the sem-

She summed up the pressure of being a consultant at such a seminar by reporting "my body arrived back in Ottawa on Sunday, my luggage arrived on Monday, and my mind caught up on Tuesday.

**Neuro Nurses Sponsor Contest** For Student Nurses In Canada

New Westminster, B.C. - The Canadian Association of Neurological and Neurosurgical Nurses (CAN3) is sponsoring a competition among Canadian student nurses for the best nursing paper in neurological or neurosurgical nursing. The paper may be a case study, personal experience, or any other aspect of neurological or neurosurgical nurs-

The association will pay the expenses of the winning student to attend the an-

(Continued on page 18)

# Famous NURSE MATES

The most comfortable white duty sharound! Styles come and go, but to classic moc toe goes on forever. Lig weight and extra-comfortable. Velve soft breathing Imperial Cushin new Pill-O-Puff cushioned seamle tongue. In privaling and mo Pril-0-Puff cushioned seamle tongue Longitudinal and me tarsal arch support, arch ve-for day-long freshness, a easy-care white washal leather. Fit guaranteed return (unmarred) size exchan No. 610 Moc Sh

New Kork-Lites Featherweight Style NEW ROTK-LIES FEATH
An extremely lightweight professions
walker, with the new "bottom" look.
Smart, comforable face-up heel
oxford over bumper foe last. Thick
simulated cork sole with 1½"
cork heel (very slip resistant,
and outwears crepe). Styled
in white washable soft glove upper leather, tricot-lined, with arch vents. The very latest reflecting trends in today's fashions.

No. 638 Kork-Lite Shoe . . . 17.00 p

#### All-Weather NURSES' CAP



t guaranteed or

for size exchange

Stay snug in cool weather, dry in the re-Traditional Navy with Bright Red lini Finest failoring of 55% Oercon polyest 35% combed cotton. Zepel treated. 10C Nylon Ouralyn lining. Snap fasteners, a openings. Matching head scart. Wash warm water, tumble dry and smooth. SM (up to 34 bust). MEDIUM (35-38) or LAR (39-42) ... specify size on coupon un-"CDIOR" 'CDLOR".

No. 658 Cape . . . . . . . 14.95 e 6-11 13.95 ea., 12 or more 12.95 e 3 Gold Initials inside collar, add 1.00 per cap

#### Cobbler-Style TUNIC

Pretty and perky over uniform, pants, skirt or dress . . . serves many needs, 200 dnr. washable Nylon Taffeta. 29" long, 20" wide. Huge, handy oversized pockets. Choose all snow-white . . or aqua or red with black trim.

No. 360 Tunic . . . 4.98 ea., 6 or more 4.50 ea. 2 Gold Initials on pocket, add \$0¢ per tunic.



2 Geld-Stamped Initials on either apren, add 50¢ per apren.



#### Nurses' POCKET PAL KIT

Handiest for busy nurses. Includes white Delt. Pocket Saver, with 5" Bandage Shear (both sho opposite page), Tri-Color ball-point pen, p handsome little pen light . . . all silver finish Change compartment, key chain.

No. 291 Pal Kit . . . . . . . 4.95 e 3 Initials engraved on shears, add 50¢ per kit.

#### Endura STOPWATCH

A fine Swiss instrument for critical timing. Records to 1/10 second (2 full revolutions per minute). Anti-magnetic, guaranteed accurate. Numerals red and black on white face. Top button starts/stops; side button returns to zero. Grey Cycolac molded case, serrated griptight edge. 18" red neck loop.

No. 15-129-1 Stop Watch . . . 19.95 ea. 3 engraved initials on back, add 1.00 per watch.



# Des

#### Pull-Out KEY-KEEPE

End fumbling for keys! Pin key-keeper on u form or in bag. Attach keys to bead chain. P out to use key, rewinds automatically. Ne convenient. Silver finish. In plastic gift ca No. 155 Keeper 2.49 € 6-11.2.25 ea. 12 or more, 2.00 ea. 3 initials engraved, add 50¢ per Keep

#### Brass DOOR NAMEPLATES

Trim, distinctive and helptul for callers. Your Name engraved and lecquered into smart solid brass 2½" doorplate. Satin gold with polished border, weather-proof finish, black lettering. Brass nails included



Print name desired clearly on separate paper.



#### 14 THE CANADIAN NURSE

# UROGATE\* The total system to meet all your irrigating requirements

Solutions
Administration sets
Drainbox\*\*

Now with the Urogate System you can choose from four handy big-mouth bottles.

You'll like the new 500 ml. and 1,000 ml. sizes. They're just right when you need smaller volumes of pour solutions.

Or, where you need *larger* volumes, the familiar 1,500 ml. and 3,000 ml. Urogate containers are ideal.

Those generous 38-mm. openings are built for business! For example, you can empty the new 1,000 ml. bottle in 10 seconds. Or empty the 500 ml. bottle in just 7 seconds.

(Or, when you choose, pour a slow, carefully regulated stream.)

No mix-up with I.V. bottles on your shelf either: you can recognize the distinctive Urogate shape at a glance. What's more, these bottles accept only Urogate urologic sets. No chance of accidental intravenous infusion.

You'll find a choice of Urogate solutions and sets for all your surgical and urologic irrigating needs. It will be worth your while to learn the details. Why not talk to your Abbott Representative this week.

# **Urogate**



#### news

(Continued from page 15)

nual meeting of CAN<sup>3</sup> in Montreal, June 10 to 13, 1973, to present her paper.

The competition is open to any student nurse of any accredited school of nursing in Canada; entrants must still be nursing students on May 1, 1973.

Submission of the paper must be accompanied by written permission from the director of the student's school of nursing, stating that the student will have leave for the period June 10 to 13, 1973, to attend the CAN<sup>3</sup> meeting, should she win.

In the event that none of the papers submitted is deemed acceptable by the program committee, there will be no student paper presented and no contest winner.

Papers must be submitted, typed double-space, before January 31, 1973, to: Marion MacKenzie, 2841 Ness Avenue, Apt. 6, Winnipeg, Manitoba, R3G 3B8.

**RNANS** Wants A Commission To Finance Postsecondary Education

Halifax, Nova Scotia — The Registered Nurses' Association of Nova Scotia has submitted a brief to the provincial health council recommending the immediate establishment of a commission responsible for financing all postsecondary education, including nursing.

The brief, "Nursing Education— Its Role in Support of Health Care Services in Nova Scotia," is concerned with the question of how nursing education in the province will be financed when present funds are no longer available. It recommends that a coordinating council be created to advise the postsecondary education commission.

RNANS proposes that representation on the coordinating council be from the governmental department and non-governmental agencies concerned with the utilization of health personnel, the educational institutions concerned with training and preparing health personnel, and the postsecondary education commission and any other institution concerned with financing education programs for health personnel.

RNANS also recommends that it retain its present functions and responsibilities related to nursing and nursing education. In curriculum development, it suggests coordination of courses basic to the curricula of the various categories of health personnel, immediate collaboration with other health science

instructors in developing programs, and development of such pilot programs by an authorized group.

One recommendation calls for professional personnel in the health categories to coordinate education programs and collaborate in developing methods for transferability and portability of skills between groups.

According to the brief. "The phrases: vertical mobility, lateral mobility, and portability, have been heard loud and clear. Every professional group seems to be deliberately delaying or sidestepping any serious consideration of the question, each thinking that no one can possibly qualify for 'our' profession unless and until they... have gone through all the hoops, hurdles, and wickets laid out in the standard curriculum of the profession. More discouraging is the seeming reluctance of everyone to even study the matter."

The brief's final recommendation is that all health personnel be licensed to practice and that a separate licensing authority for each health profession be set up. RNANS calls for representation on each licensing authority from the health profession concerned, the consumers of the services, the related health professions, the appropriate government body, and an educational agency concerned with the specific health profession.

Explaining the purpose of its brief as its concern about the quality of nursing care and its anxiety to see nurses prepared as competently as possible, RNANS notes, "It is not good enough merely to say that we are for excellence without suggesting the means to secure excellence."

RNAO Sponsors Summer School On Collective Bargaining

Toronto, Ont. — This year, for the first time, the employment relations department of the Registered Nurses' Association of Ontario is holding a collective bargaining summer school, scheduled from June 3 to 9 at Glendon College, York University, Toronto.

Plans for the summer school call for all aspects of collective bargaining to be covered, with special attention to the problems of administration of local nurses' associations, negotiations, and grievance procedures.

Movies, debate on the merits of strike versus arbitration, and pressing issues in industrial relations will also be included. Arthur Kruger, professor at the University of Toronto who specializes in labor economics, will be one of the speakers.

George Richards, RNAO employment relations officer, called the summer school "total immersion for a week." He told *The Canadian Nurse* 

the purpose was to discuss all aspects of collective bargaining as it relates to nurses, and specifically to develop a corps of leaders able to assist RNAO staff who represent the nurses.

Applications for the summer school should be made as soon as possible. There is a registration fee of \$75 per student, which covers room and board and all materials. Further information is available from George Richards, Employment Relations Officer, RNAO, 33 Price Street, Toronto 5, Ontario.

### Three Toronto Institutions Unite To Help Prevent Child Abuse

Toronto, Ont. — The Hospital for Sick Children, the Children's Aid Society of Metropolitan Toronto, and the Catholic Children's Aid Society have appointed Ruth Koch-Schulte as a senior social worker to work full time at the hospital to integrate all services of common concern to the three institutions.

Ms. Koch-Schulte, a social worker at the hospital for the past six years, will work in the areas of child neglect handled by the hospital and by Children's Aid workers. These areas include battered children, sexual assaults and other forms of child abuse, and guardianship problems, such as abandoned babies or runaway teenagers who may need hospital care.

In 1971, the hospital referred 108 suspected cases of child abuse to the Children's Aid Societies. With the appointment of Ms. Koch-Schulte, it is hoped that positive help can be given

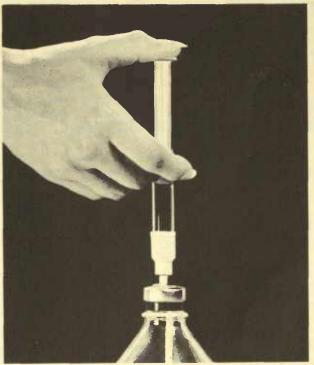
to families with problems.

According to Shirley Stinson, director of social work at The Hospital for Sick Children, "Sometimes we can spot the early signs. These people are really crying for help, and we hope we can do much more to provide this by teaming up with the Children's Aid, Along with helping the children themselves, this team approach to help the family is a major objective of these new arrangements,"

Before she began her new job in September 1972, Ms. Koch-Schulte spent a month at the two Children's Aid Societies to gain first-hand experience of their work. As well as being involved in the child-neglect cases handled at the hospital, her position as senior social worker will include acting as liaison between the hospital and Children's Aid staffs, providing consultation on cases of mutual interest, and improving communications and contacts between the hospital and the societies in these specialized fields.

# Here is a new, fast and sterile way to prepare Xylocaine infusions

for life threatening arrhythmias



# **Xylocaine**®

(Lidocaine Hydrochloride Injection, Astra Std.)

# ne Gra

- The special 5 ml transfer syringe contains 200 mg/ml Xylocaine and can be added to infusion set-ups without removing solution from infusion flask or bag
- Cuts preparation time in half
- Easy and convenient to use
- Adds another link to the sterility chain
- Disposable
- Clearly labeled for positive safeguard against error

ASTRA Pharmaceutical Division, Mississauga, Ontario



ASTRA

# For the nurse who never wants to stop learning

Saunders has the text to meet your needs

# Gillies & Alyn: Saunders Tests for SELF-EVALUATION OF NURSING COMPETENCE New 2nd Edition

Here's an easy and reliable volume for review and examination of nursing methods, professional skills and medical facts. Presents a collection of representative clinical situations, each with a series of multiple-choice questions to test the reader's recall of facts and her ability to apply those facts to the resolution of actual problems encountered in practice. Ideal

for students and graduates preparing for exams, the nurse returning to practice, or the teacher who wants an outline of significant nursing content. By Dee Ann Gillies, R.N., Ed.D. and Irene B. Alyn, R.N., Ph.O. About 495pp. About \$7.75. Just Ready.

### Spencer: PATIENT CARE IN ENDOCRINE PROBLEMS

A comprehensive, clinically oriented text for nursing care in diseases and disorders of the endocrine system. Reviews physiology and pathophysiology of each endocrine organ; and discusses the diseases affecting the organ, their treatment and nursing care. A case study, or "patient portrait," is

included for each major disease entity. Special attention is given to iatrogenic conditions arising from hormone therapy. By Roberta T. Spencer, R.N., M.S.N.E. About 225 pp. Illustd. About \$10.30. Just Ready.

# Irving: BASIC PSYCHIATRIC NURSING

This basic text details the duties, responsibilities, and types of care in psychiatric nursing today. In a series of clearly written chapters the author discusses such subjects as: mental health and nursing; basic human needs; reaction to stress; psychiatric treatment and psychoactive drugs; schiz-

ophrenia; reactions to the aging process; and much more. Includes appendices providing lists of mental disorders and psychoactive drugs, a glossary of psychiatric terms, and a bibliography. By Susan Irving, R.N., M.S. About 250pp. Soft Cover. About \$5.15. Just Ready.

# Stryker: REHABILITATIVE ASPECTS OF ACUTE AND CHRONIC NURSING CARE

This authoritative book stresses the need for the nurse to know how to help the patient deal with his rehabilitative problem; and demonstrates how to implement rehabilitative steps in acute and long term care. Restorative care of the chronically ill and disabled is discussed in detail. By Ruth Perin Stryker, R.N., M.A. 236 pp. Illustd. \$8.00. April 1972.

#### Falconer et al: CURRENT DRUG HANDBOOK 1972-74

In the latest edition of this handy reference, concise clinical data is given on more than 1500 drugs in current use. Parallel columns list name, source, synonyms, preparations, dosage and administration, use, action, side effects and contraindications, and remarks about each drug. New

drugs that are in general use have been included and information has been updated throughout. By Mary W. Falconer, R.N., M.A.; H. Robert Patterson, B.S., Pharm. D. and Edward A. Gustafson, B.S., Pharm. D. 250pp. Soft Cover. \$5.40. March 1972.

#### W.B. SAUNDERS COMPANY, CANADA LTD.

833 Oxford Street, Toronto 18

City	Prov.	
Nama	4131 Gillies & Alyn; Self-Evaluation (2) About \$7.75, 8517 Spencer: Endocrine Problems About \$10.30, 5045 Irving: Basic Psychiatric Nursing About \$5.00.	8636 Stryker: <b>Rehabilitative Aspects</b> \$8.00. 3565 Falconer et al: <b>Drug Handbook '72-74</b> \$5.40.
	Please send me on 30-day approval:	

# Needed: a change in attitudes toward elective sterilization

Lise Fortier, M.D., F.R.C.S.(C)



Male and female attitudes to sterilization are so far apart that you would think only one partner derives advantage from it. Men shun sterilization; women beg for it, even when their reason for doing so has nothing to do with themselves. They will beg for it because the husband is alcoholic, epileptic, suffers from heart disease or a nervous breakdown, or simply to make sex more enjoyable for the partner.

A man whose wife has had six pregnancies, two miscarriages, two curettages, phlebitis, has taken pills for six years, and has varicose veins still thinks it is his wife who should submit to sterilization. After all, she is used to general anesthesia and operative procedures. Why make a fuss about one more operation?

Even when you have explained to some women how much more complicated it is to sterilize them than their husbands (it implies a hospital stay, major surgery, and convalescence), they still insist on being sterilized themselves. Further, male physicians, probably sensing that they themselves could be patients, discourage men from being sterilized by frightening them with improbable predictions or complications.

Medicine is still a man's world, and men who become physicians are not entirely free of their male prejudices nor of their desire to dominate females.

#### Freudian influence

Psychiatry has done little to change these attitudes. Freud described envy of the penis as an essential component of feminine psychology. He and many of his followers considered woman incomplete, a being without a penis. Surprisingly, they never saw man as having no uterus! The functioning of such an incomplete being as woman could not possibly be normal, so this had to be modified.

From this came what I call the "delirium of the vaginal orgasm." Common sense shows that the clitoris is the physiological counterpart of the penis, and thus the seat of orgasm. Men, wanting to believe that merely introducing the penis into the vagina should give women great ecstasy, invented the idea that in women orgasm is transferred from the clitoris to the vagina. This does not take into consideration the natural insensitivity of the vagina, into which a foreign body can be introduced and as soon forgotten.

Using the same line of reasoning, ovaries were removed for the most tenuous of reasons, yet testes were not removed unless death threatened. A psychiatrist once asked me to sterilize a young woman whose suicidal tendencies were, in his opinion, apparent only during her premenstrual period. It would not have occurred to him to castrate a man if similar suicidal tendencies had appeared after an ejaculation.

#### Preoperative consultation

In some Canadian and American hospitals, there must be consultation before sterilizing a woman who is in her re-

ries and Gynecology at Hôpital Notre-Dame, Montreal, and Associate Professor of Gynecology, University of Montreal. This article is adapted from a paper she presented at the meeting of the International Planned Parenthood Federation, Western Hemisphere Region, in Ottawa, May 8, 1972.

Dr. Fortier is Senior Assistant in Obstet-

productive years. Was this introduced because unscrupulous physicians had been performing hysterectomies as a quick way to fortune? If so, why is consultation still required for women who have cancer, but not once they have passed their reproductive years? Why is consultation not needed for tonsillectomy or appendectomy (two operations that are done without rhyme or reason), nor prior to craniotomy or gastrectomy? Here it seems that a tissue committee is sufficient.

Does all this mean that, in the eyes of a physician, the reproductive function of a woman is more important than her life? A woman should not be deprived of this function except for very serious reasons; she must not escape pregnancy!

In some hospitals, consultation is mandatory for cesarean section. There was a time when everything else was tried first, short of killing the mother, so that she would come for cesarean section almost moribund. Thus, consultation for cesarean section seems to me a bad joke. One wonders where all these precautions originated. The chief causes of maternal mortality - hemorrhage, toxemia, infection - have in great measure been controlled by cesarean section, a procedure so benign that it can be compared to a normal delivery. Could it be that suspicion is cast on everything that permits a woman to free herself from the danger and pain of having a child?

Before hastening to refute this seemingly ridiculous hypothesis, recall earlier objections to the use of anesthesia in obstetrics. Women were meant to give birth in pain. Once women decided to get rid of this attitude, they demanded anesthesia for delivery. As anesthesia and analgesia were dispensed for other conditions that caused pain, or for other operations, it was rather embarrassing to refuse them for obstetrics.

Naturally, anesthesia is dangerous to the mother and to the infant. Although the dangers of anesthesia in any other operation are accepted as an inevitable part of the fight against pain, it was thought that doing without anesthesia in obstetrics would benefit the child. This is a worthy end, but pregnant women were never asked their opinion on the subject, as everything was decided by physicians.

Physicians also have tried to convince women that they would be superior females and mothers if they did completely without anesthesia. Thus, natural childbirth brought women back

exactly to where they had been before the discovery of anesthesia.

Why has so much attention been given to surgical anesthesia which, after all, many persons may never experience in their lifetime, while the relief of obstetrical pains experienced by most women, and repeatedly so, has evoked so little attention? I am convinced that, if men had babies and suffered the pains of childbirth, research in this area would long ago have produced a safe and easy way to relieve pain.

#### Pregnancy considered normal state

Many physicians have tried to convince women that pregnancy is a normal situation, desirable physiologically and socially, and that to avoid pregnancy spells failure. These same physicians keep silent about the real dangers of pregnancy. The mortality rate of around 45 per 1,000 did not decrease until knowledge of the important changes produced in the organism by pregnancy made physicians treat it as a disease demanding intensive care.

Whenever I point out to other physicians that maternal mortality decreased only when they started treating pregnancy as a disease, even the most broadminded of them tell me that pregnancy is, after all, a normal function of the organism. Certainly it is a function and, if normal means that it is shared by most, it is a normal function. But I cannot agree that it is normal in the sense that, like other functions, it helps maintain the health of the organism.

I do not say pregnancy is a discase, because I am not sure what a disease is, nor how to define it, if not by defining health. But, pregnancy is a departure from the state of health, or an abnormal state of the body as a whole, which manifests itself subjectively by abnormal sensations essentially unpleasant, worrying, or painful.

Certainly many women, from the beginning of pregnancy, have a series of abnormal sensations or symptoms that are essentially unpleasant, worrying, or painful. To enumerate a few: nausea, vomiting, sleepiness, fatigue, constipation, shortness of breath, striae gravidarum, edema, and backache. A climax is reached at delivery, with all the pains, bleeding, and tears that accompany it. Later, complications such as prolapse, cystocele, and rectocele may occur.

I have not included the specific complications of pregnancy, such as miscarriage, placenta praevia, abruptio plancentae, toxemia, the multiple

complications of labor that demand delivery by cesarean section, nor postpartum psychosis. Also, the more numerous the pregnancies, the greater the risk to the health of the mother. Maternal deaths directly related to multiparity would be greatly reduced if contraceptive methods were used.

#### Sterilization difficult to achieve

When a woman does not want any more children and asks for a means to put an end to her child-bearing capacities, she has little chance of obtaining it. Elective sterilization is done in only a few Canadian hospitals. This means that surgical sterilization of females has generally been limited to those cases where pregnancy would threaten the health of the mother. Hence, real, effective sterilization barely exists.

Some hospitals apply the rule of 120, which is the number one must arrive at before permitting sterilization. This is the age of the mother multiplied by the number of her children. Thus, a woman of 20 must have six children, and one of 30 must have four, before being eligible for sterilization. This formula is little more than an attempt to avoid basing a decision on individual factors in a given patient. This seems ridiculous when we are reaching the conviction that our population growth should be zero!

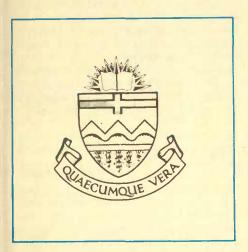
#### Conclusion

A good gynecologist, consulted about a patient who, without any known pathology, had had nine successive miscarriages, more complicated each time and needing more and more blood transfusions, refused to sterilize her. To those who objected because of the dangers incurred by the patient, he answered: "What can we do? This is the destiny of women." This attitude of resignation is contrary to medicine's reason for existence, which is to help people fight an ill-fated biological destiny.

We have a commitment to see that every woman who ventures into pregnancy does so of her own free will, with a realistic knowledge of the dangers inherent in the situation, and with the possibility of defending herself against them, so that every birth becomes a desired and happy event.

# University schools of nursing in Canada

Each of Canada's twenty-two university schools of nursing describes the programs to be offered in the fall of 1973.



# University of Alberta

The University of Alberta school of nursing is located in Edmonton on a 154-acre site on the bank of the North Saskatchewan River, within the university's health sciences complex.

The school offers a four-year integrated baccalaureate program for high school graduates, leading to the bachelor of science in nursing degree, and a two-year baccalaureate program for registered nurses.

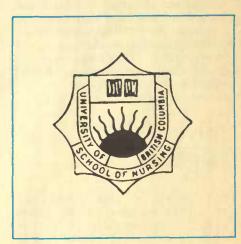
Admission requirements for the degree programs include Alberta senior matriculation or equivalent with a 60 percent average in five required subjects, although a 65 percent average is required for admission to the basic program. Registered nurses must be

graduates of approved diploma schools of nursing and eligible for registration in Alberta. Because of the need to limit enrollment in the degree programs, preference is given to Alberta high school graduates and registered nurses working in the province. Applications for admission should be made before May each year.

The certificate program in advanced practical obstetrics, equivalent to Part I midwifery, is designed to give advanced preparation to registered nurses who work in obstetrical units of hospitals or in outlying areas where medical services are limited.

A two-year program leading to the degree of master of nursing, with a major in nursing in acute illness, is planned for September 1973. A twoyear program leading to the degree of master of health services administration, with a major in nursing service administration, is offered by the division of health services administration. This program is designed to prepare nurses for senior administrative positions, and details may be obtained from the director, division of health services administration, University of Alberta. Academic admission requirements for the master's degree programs are a baccalaureate degree in nursing with at least a 65 percent average in the academic work of the last two years of the bachelor's program.

For complete information about nursing programs, individuals should write to Ruth E. McClure, Director, School of Nursing, University of Alberta, Edmonton, Alberta.



# University of British Columbia

The school of nursing, an integral part of the university's developing health sciences centre, is located in Greater Vancouver. It offers an integrated baccalaureate degree program for qualified high school graduates and for registered nurses eligible for admission to the university. The school also offers a program leading to a master's degree in nursing.

The program leading to a baccalaurreate degree prepares its graduates to work in hospitals and in the community, with individuals and families in any

stage of health.

The master's program is designed to help the student develop increased knowledge and skills in a clinical nurs-



ing area. It also provides opportunity to explore a functional role, such as administration, teaching, and research.

Admission to the university requires a mininum of British Columbia secondary school graduation, or its equivalent, with a 65 percent average. Admission to the master's program requires completion of a baccalaureate program in nursing with good academic standing. Consideration is given to nurses with baccalaureate degrees in other disciplines. It is necessary that nurses be registered in British Columbia or another Canadian province.

For further information, write to the Registrar, University of British

Columbia, Vancouver 8, B.C.

# University of Calgary

The University of Calgary had its origins in 1945 and since then has grown rapidly to accommodate a current student population of about 9,000. Situated in the northwest section of the city, it is surrounded by a Rocky Mountain panorama. The university gained full autonomy in 1966.

The school of nursing was established on an independent basis within the university administrative framework in 1969, and offers a four-year basic baccalaureate course, which commenced September 1970. After completing this program, the student will be awarded a bachelor of nursing degree (B.N.) and will be eligible to write licensure examinations to practice nursing in Canada.

The student is enrolled in the university in each of the four years and will pursue simultaneous study in the humanities, sciences, and nursing in each of these years. Clinical experience is obtained in conjunction with several hospitals and community health agencies and is associated with courses in

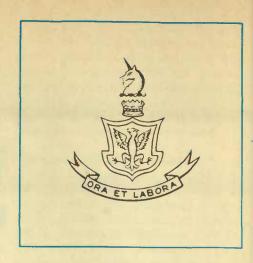
nursing content throughout each academic year.

Significant features of the program include emphasis on the Canadian cultural milieu and on flexibility to allow for individual differences. Each term allows for at least one elective area of study, and in the final year there will be an opportunity for independent study in nursing. Intersessional periods of continuous clinical practice are held in the spring; however, a minimum of two summer months is free of classes and clinical experience. Admission of postbasic students to the baccalaureate program is under consideration for 1974.

The purpose of the school is to prepare nurses who are qualified to assume first-level positions in professional nursing. The curriculum is designed to prepare a generalist in professional nursing, rather than one who has received specialized preparation in functional areas, a philosophy compatible with national professional standards. The faculty of the school are committed to preparing nurses to function in new and challenging roles in a variety of settings with particular emphasis on the role of family nurse practitioner.

Students from high schools in Alberta are admitted on presentation of Alberta Grade 12 senior matriculation with an overall average of at least 65 percent, and with 50 percent or equivalent letter grade standing in the required courses. Students from outside the province are evaluated on an individual basis. Enrollment in the school of nursing is limited to 60. Further information may be obtained from the registrar's office.

The Acting Director of the School is Dr. F. Terentiuk.



#### Dalhousie University

Dalhousie Univeristy in Halifax, Nova Scotia, was founded in 1818. The Carlton campus, where the faculty of health professions — nursing, pharmacy, physical education, and physiotherapy — and the faculties of medicine and dentistry are situated, is in the southwestern section of Halifax. Nearby are many of the city's health agencies and hospitals.

The school of nursing was organized in 1949 and has developed according to the needs of the Atlantic region. A special working relationship exists with the Mount Saint Vincent University, where students may obtain a nursing degree while taking the nursing courses

at Dalhousie University.

The school of nursing offers a fouryear baccalaureate degree, a three-year post-R.N. baccalaureate degree, and diplomas in public health nursing, nursing service administration (last class in 1973-74), and also the two-year diplo-

ma in outpost nursing.

The basic baccalaureate program is an integrated one with emphasis on assisting man to maintain optimal health throughout his life. Streams run throughout these four years and include the nursing specialities of medical-surgical, psychiatry, maternal-child health, community health, as well as those of nutrition and pharmacology. These streams are developed around certain basic core concepts and principles that progress at increasing levels of complexity in various environments and with people of all age groups who have a variety of health problems. Consequently, there is a constant interplay between physiological, psychological, and sociocultural factors that are present in the nursing process at every phase of the health maintenance, restorative, and rehabilitative cycle. Throughout the four years, various



teaching modalities are used with emphasis on learning at the interdisciplinary level.

ary level.

The three-year post-R.N. baccalaureate program is progressively being integrated with the basic program, particularly in the last two years of each program. The mature student who has not the usual academic qualifications is especially considered and accepted.

The outpost nursing program was originally designed to prepare nurses for responsible positions in northern Canada. Recently, it is attracting nurses from more international settings. Midwifery is a part of this program.

For further information about our programs, write to the Director, School of Nursing, Dalhousie University,

Halifax, Nova Scotia.

#### Lakehead University

Lakehead University, architecturally blended into its natural picturesque surroundings, is situated centrally within the city of Thunder Bay. The campus, because of its central location, is readily accessible to the varied recreational facilities for which northern Ontario is famous. Being one of the smaller universities, with an average enrollment of 3,000, Lakehead University can and does offer the personal touch to students who enter its doors. The university offers a wide spectrum of courses from which to choose, both at the undergraduate and graduate levels.

The school of nursing, which admitted its first students in 1966, offers two programs, both leading to a bachelor of science of nursing degree. The four-year generic program (basic) is designed for the high school graduate; the integrated three-year program (post diploma) is offered to registered nurses

who wish to pursue a baccalaureate

Admission to the school may be attained either by successful completion of Ontario Grade 13 or its equivalent, or by invoking the mature student clause. Under this clause, residents of Canada 23 years of age or over, who have not attended postsecondary institutions for two years prior to admission, are considered as adult students. Regardless of the method of entrance into the school, Grade 13 chemistry and biology are prerequisites.

Lakehead University upholds the philosophy of interdisciplinary education and the school of nursing curriculum reflects this approach. The clinical component of nursing with its emphasis on family-centered care at the baccalaureate level is reinforced throughout both programs. Appropriate field experiences within the community health care agencies, including the

home, are provided.

A brochure outlining further information is available on request. Those interested in applying for either of the programs should direct their inquiries to Dr. Jane Holliday, Director and Professor, School of Nursing, Lakehead University, Thunder Bay, Ontario.



# Laurentian University

Laurentian University is situated on a beautiful campus in Sudbury, northern Ontario. The school of nursing, one of six professional schools of the university, admitted its first students

September 1967.

Entrance requirements: Students from Ontario are normally expected to have completed a full Grade 13 arts and science program. A minimum of six credits and an overall average of at least 60 percent are required, and must include the following subjects: English or français, chemistry and biology. Equivalent academic standing is required for students from other provinces or countries.

Students study for the BScN degree; after passing the Ontario nurse registration examination, they are qualified to practice nursing in hospitals or public health agencies and are prepared to advance professionally, without further formal preparation, in all nursing positions for which a bachelor's degree is preferred. Graduates of the program who wish to study at the master's or doctoral level have a sound basis for advanced study.

Approximately 50 percent of the curriculum consists of liberal arts and sciences, which are open to all students in the university. All nursing courses are under the control of the faculty of the school of nursing and are taught on campus and in local hospitals and health agencies. Expanding hospital, medical, and public health facilities ensure that a good variety of clinical experience is available.

Faculty and students are completely accepted as members of the university community and participate fully in the life of the university and its varied activities.

The university senate has given approval in principle for a post-basic

THE CANADIAN NURSE 25



BScN degree for registered nurses. Entrance requirements for it will include Ontario Grade 13 English or français, and Grade 13 chemistry and biology with a minimum average of 60 percent. Equivalent academic standing will be required for students from other provinces or countries.

Inquiries should be sent to: Dr. Margaret Lee, Director, School of Nursing, Laurentian University, Ramsey Lake

Road, Sudbury, Ontario.

### Laval University

The school of nursing of Laval University was created in 1967 to develop and control the curricula leading to university degrees in nursing. Since 1968, the school has been integrated with the health sciences department, and nursing students register for the same basic courses as other health science students. It is anticipated that through this initiative, students in various disciplines of the health field will be in a better position to perceive the similarity of their scientific and professional interests and will learn to team together at the outset of their university studies.

The curriculum offered at present has been developed to enable students to reach the objectives of the first level of a university education. It is made up of two groups of subjects: the basic subjects related to biologic and behavioral sciences and those pertaining to

nursing practice.

The 96 credits of the entire curriculum are usually spread over six semesters to which are added four to six weeks of clinical practice at the end of the first and the second year. At the end of the program, students receive a baccalaureate in health science with a major in nursing science. One hundred and fifteen students are at present registered at the school.



Applicants to the program must hold a diploma of college level or the equivalent. They must also have had preadmission courses in the profile of biological sciences.

Applications should be addressed to Service d'admission, Université Laval, Québec 10e. Rita Dussault is Director

of the School of Nursing.



The University of Manitoba, established in 1877, is situated on the banks of the Red River about seven miles from downtown Winnipeg. In 1929 the 663-acre site in Fort Garry, occupied by the Manitoba Agricultural College since 1913, was chosen as the permanent site of the university. Courses in nursing were first offered in 1943.

The present nursing program offers a four-year integrated course leading to a bachelor of nursing (B.N.) degree. In the first three years, the academic year in nursing is from September through June. In the final year, it is from September to early May.

The bachelor's program for registered nurses approximates the four-year curriculum, requiring about three years to complete. At least two full years of the program must be taken at the University of Maritales.

versity of Manitoba.

Several institutes are also offered each year to meet special needs of nursing groups, such as supervisors and instructors.

Minimum requirements for entrance include Manitoba Grade 12 — senior matriculation — and the prerequisite

high school subjects.

Those interested in applying should write for complete information on admission requirements and courses offered to: Dr. Helen Glass, Director, School of Nursing, The University of Manitoba, Winnipeg, Manitoba R3T 2N2.



### McGill University

The focus of all programs at the baccalaureate and masters levels in the school of nursing, McGill University, is to prepare nurses for an expanding role in the developing health services. The goal is to enable the graduate to be an expert practitioner of nursing who is capable of exploring the nursing function in these services and thereby to participate actively in their development. The creation of new entities and of new structures and roles within traditional institutions is being actively pursued by faculty engaged in nursing in these evolving services.

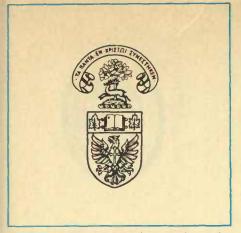
The basic baccalaureate program is three years in length following Quebec Grade XI and two years in the biological (health) sciences stream of Quebec CEGEP or the university equivalent. High school graduates from outside the province and holders of the CEGEP collegial diploma in the nursing option are considered on the basis of their educational profile and might complete the requirements for the BSc(N)

degree in less than five years.

The bachelor of nursing program, designed for graduates of hospital programs in nursing, comprises two years of study following Quebec Grade XI and one additional year of general education in CEGEP or university. In both baccalaureate programs, academic and professional courses are integrated, with a focus on nursing practice in homes, hospitals, and other health

agencies.

The two-year program leading to the degree of master of science (applied) prepares the specialist in nursing who is equipped to promote the development of nursing through research, education, or service. The core of the program focuses on the study of nursing: examination and analysis of experience, and intensive investigation of more specific phenomena and prob-



lems. Students may also explore the process of learning to nurse and the implications for teaching and curriculum, or may be concerned more directly with change and development in nursing service and the health field.

A one-year program leading to a master of nursing prepares teachers of nursing for the new educational programs in Canada. Throughout the course and in the two-month internship, beginning specialists in nursing, that is, highly qualified graduates of four- or five-year basic nursing university programs, participate in teaching nursing in many clinical settings. Courses in psychology, anthropology, sociology, and education assist in exploring how students learn to nurse and in testing related teaching practices.

The Director of the School of Nurs-

ing is Joan M. Gilchrist.

#### McMaster University

The school of nursing is an integral part of McMaster University in Hamilton, Ontario. Nursing students share the academic and educational resources, as well as the social and recreational facilities, with other students.

The school is located in the university health sciences centre, which houses a university hospital, ambulatory patient care services, and a health sciences library and learning resource center, as well as providing extensive facilities for research. These resources are shared with the faculty of medicine and regional health-care educational programs.

The school currently administers two programs, the four-year undergraduate program leading to the degree bachelor of science in nursing (B.Sc.N.) and an eight-month certificate program for the training of family practice nurses.

The baccalaureate program qualifies students for first-level positions in hos-

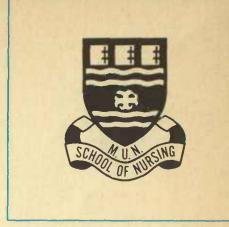
pital, community fields, and primary care settings, and prepares students for nurse registration under the College of Nurses of Ontario. The broad background of general education offered in the program provides the necessary foundation for graduate study in nursing.

The study of nursing spans the four years of the program. From an introduction to health needs of individuals and families, the student is helped to evaluate the basic nursing needs of patients, and in the first year has the opportunity to plan and give nursing care in the hospital. In subsequent years, nursing study prepares the student to provide increasingly complex nursing care to patients and their families in hospital, ambulatory, and community settings. In all years, the theoretical basis for the study of nursing is general systems theory.

Admission requirements are Ontario Grade 13 or its equivalent, with certain prerequisite subjects. Applications from students from all provinces and from other countries are welcomed. Year I enrollment is limited to 75 students.

The family practice nurse program is planned to provide registered nurses who are working with a family physician with the knowledge, understanding, and skills necessary to enable them to assume responsibilities that include initial assessment of a patient's or family's health problems, health teaching, and counseling of individuals and families regarding health-related situations. The participation in the program of a physician-sponsor is required.

Plans are now underway in the university to offer a program leading to the degree, master of health sciences (health care practice). This will be an interdisciplinary program, appropriate for several of the health-related professions. Clinical majors for nurses will be planned in primary care nursing and maternal-child nursing. A second master's program to prepare health care researchers is now in operation. The latter program leads to a master of



science (health care evaluation).

As the number of applicants for admission to all these programs is always greater than the number of vacancies, prospective students should apply as early as possible. Further information may be obtained from Dr. Dorothy Kergin, Director, School of Nursing, McMaster University, Hamilton, Ont.

# Memorial University

Memorial University is situated in the lovely old city of St. John's. It is surrounded by hills and valleys overlooking famous Signal Hill, with Cabot Tower standing high on a rock at the entrance to the harbor.

The university school of nursing admitted its first students to a basic, integrated baccalaureate program in Sep-

tember 1966.

Registered nurses who are residents of Newfoundland and entered hospital schools of nursing before 1971 can enroll as mature students in the degree program. Nursing credits are transferable.

The program extends over four years. Students are admitted after successful completion of the first year at Memorial. Biology and chemistry are required

and physics is advantageous.

Each year the students gain nursing experience in hospitals and agencies, under the direct supervision of university teachers. A six-week extended lab practice period is added in May-June of the first two years of the program.

Enrollment is limited to 40 students in the first year to permit a workable student-teacher ratio and to keep within the limits of available clinical practice facilities. Male students are welcomed.

Students from the school are elected as representatives to various administrative, faculty, and student committees and organizations of the university.

Applications should be made to the



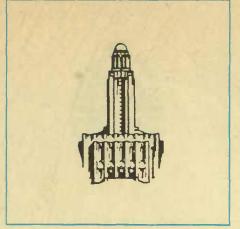
registrar of the university. Further information about the school can be obtained from Director, School of Nursing, Memorial University of Newfoundland, St. John's, Newfoundland.

# University of Moncton

When the University of Moncton in New Brunswick received its charter of incorporation, other French-language institutions for higher learning in the province became affiliates of the university. These included Collège Saint-Joseph, Collège Saint-Louis, and the Collège Sacré-Coeur. Degrees are granted by the university.

As early as 1964, the University of Moncton recognized the needs of New Brunswick's French-speaking nurses in nursing education. With the encouragement of the New Brunswick Association of Registered Nurses, Jacqueline Bouchard was appointed to organize and direct the university's Ecole des sciences infirmières. This school has the same academic status as other faculties and schools within the institution. The director is a member of the academic senate.

In 1965, a four-year program of studies leading to a degree in nursing science was inaugurated. Applicants must have completed Grade 12 or equivalent from another province, and must have 50 percent in each of five specific examinations set by the New Brunswick department of education. Students receive intensive clinical experience during the summer months of the first three years in addition to two clinical days during each week of the second, third, and fourth academic year. The school maintains complete control over the program. Agreements have been reached between the university and certain agencies and hospitals



in the area and outside to provide facilities for clinical practice.

In 1966, a three-year program that provides for completion of studies at the baccalaureate level was begun. Applicants must be graduates from approved schools of nursing and be registered nurses. Courses in psychiatry and public health are requisites for the degree. However, they must be completed outside the regular academic program, which combines general and professional learning. A reorientation of this program is now being contemplated.

# University of Montreal

The faculty of nursing of the University of Montreal was founded in 1962. Marguerite d'Youville Institute, founded in 1934 as a college of nursing affiliated to the University of Montreal, was integrated in the faculty of nursing in 1967. The school for public health nursing, which was at first a part of the school of hygiene and public health, had been previously integrated in the faculty in 1964. At the time of integration, this latter program, as well as the certificate programs of L'institut Marguerite d'Youville, were ended and only the baccalaureate and masters' programs were continued. In May 1973, the special baccalaureate program for graduate nurses will be terminated; 1,385 nurses will have benefited from

In September 1973 the following programs will be offered: B.Sc. (Nursing); and master's in nursing education, administration in nursing services, psychiatric nursing, and medical and surgical nursing.

Admission to the baccalaureate program requires a CEGEP diploma with option in the biological sciences as required for all health disciplines. Admissions have been raised to 100 for the

first year; the baccalaureate program is three years.

For graduate nurses who can comply with the admission requirements, there will be flexibility in the program, taking into account their former preparation and experience, and their adult status.

Applicants to the master's program must have a baccalaureate degree in nursing or its equivalent. The program covers two academic years and requires a thesis. Admissions to each option of the program are limited to eight candidates.

The faculty of nursing with the cooperation of the department of continuing education also offers a one-year program in community nursing leading to a certificate issued by this department.

The faculty of nursing in cooperation with the Canadian Nurses' Association and the Canadian Hospital Association supervises the French-language section of the course in nursing unit administration. A certificate signed by the two sponsoring bodies is awarded when studies are completed.

The faculty also assists in preparing French-speaking personnel for service in countries that receive assistance from CtDA.

Dr. Alice Girard is Dean of the Faculty of Nursing.



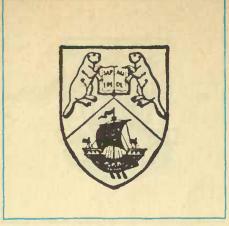
#### Mount Saint Vincent University

Mount Saint Vincent University in Nova Scotia is the only independent women's university in Canada. It is a Catholic institution for higher education, conducted by the Sisters of Charity. Located in Rockingham, about a 20-minute drive from downtown Halifax, the campus overlooks Bedford Basin. The university is growing rapidly. Among the most recently completed buildings are a tower residence and a student union building, an academic center and auditorium, and five townhouse residences.

The basic nursing program is a fouryear, integrated program leading to a bachelor of science in nursing degree. Under a new agreement with Dalhousie University, nursing courses are centralized at Dalhousie, with students taking arts and science courses at Mount Saint Vincent. The course includes three summer sessions. Hospital practice is given in Halifax hospitals and health agencies under direct supervision of the

university nursing faculty. A degree program is also open to registered nurses who have completed one-year university certificate courses in a nursing specialty. Nurses in this program must complete 10 courses in science and liberal arts subjects. This program, instituted to meet a pressing need for nurses with degrees in administrative and teaching positions in Nova Scotia, will be offered for a limited time. Deadline for admission to this program is September 1973; deadline for completion is August 1975. Graduate nurses who are interested in continuing their studies after this time will be considered on an individual basis. No certificate courses are available.

Admission to the basic four-year integrated program requires a Nova Scotia Grade 12 high school pass certificate in the university preparatory



program, or its equivalent. Married women may apply, and although the university is primarily for women, men may apply. About 20 students are admitted to each new class. Interested candidates should write to the Admissions Office, Mount Saint Vincent University, Halifax, Nova Scotia.

# University of New Brunswick

The University of New Brunswick, one of Canada's oldest universities, is situated on a hillside overlooking the Saint John River. The school of nursing was established in 1958 and the first students enrolled a year later. In 1969 the school became the faculty of nursing and now occupies a new building named Katherine MacLaggan Hall.

Two programs are offered: a fouryear basic degree program and a threeyear program for registered nurses. Both programs, which lead to a bachelor of nursing degree, are generic, without specialization; both include public health nursing integrated within the professional content, and courses in general education in the faculties of arts and science.

The basic degree program extends from mid-September until approximately the end of June. The theory and practice of nursing are arranged concurrently and sequentially throughout the four years in community agencies and hospitals. An eight-week period of concentrated practice is arranged during May and June at the conclusion of the first, second, and third years.

The program for registered nurses is given during the academic year. The courses in nursing, including public health, are arranged sequentially during the three years. Observations and practice are planned at appropriate points in conjunction with the nursing theory. Psychiatric nursing is arranged for stu-

dents who have not previously had such experience. Required and elective courses offered during summer school or in the extension department may be taken after consultation with the dean of the faculty of nursing. The final year must be spent in full-time study on the Fredericton campus.

Entrance requirements for applicants to the basic degree program include a 70 percent average on New Brunswick departmental examinations in six subjects, and for the registered nurses, at least a 60 percent average is required. SACU tests are required for applicants leaving secondary school after 1970. Male and female, married and single applicants are given equal consideration.

Further information may be obtained by writing to the Dean, Faculty of Nursing, University of New Brunswick, Fredericton, N.B.



#### University of Ottawa

The University of Ottawa, first incorporated as the College of Bytown (1848) and later as the College of Ottawa (1861), was granted a royal charter as a university one year before Confederation. Founded by the Oblate Fathers and administered by them for over a century, it became a provincially-assisted university, administered by a board of governors, on July 1, 1965.

September 1973 marks the fortieth anniversary of the opening of its school of nursing, which, until 1961, offered a three-year bilingual diploma program

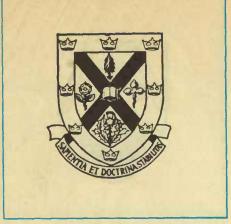
in nursing.

Certificate and baccalaureate programs in nursing education and in public health nursing were first offered to registered nurses in 1943. The certificate programs were discontinued at the end of the 1970-1971 academic year, and candidates for these degrees must complete their requirements prior to October 1973.

In 1961 the school established a basic four-year integrated degree program leading to a bachelor of science in nursing. Its graduates are prepared for first-level positions in hospitals and community health agencies, and for advancement to positions requiring

administrative skills.

A three-year degree program for registered nurses admitted its first students in 1971. It is designed to broaden the student's concepts of nursing, increase clinical competency, and develop leadership ability. The courses of the first year of the program máy be taken on a part-time basis, and transfer of credit may be granted for equivalent courses taken in another university. During the final two years, candidates for the degree must be registered as full-time students in this school of nurs-



The academic admission requirement to both B.Sc.N. programs is Ontario Grade 13, or equivalent, standing in English or French, chemistry, biology, and at least two other acceptable subjects for a minimum of six credits and an overall average of at least 60 percent. Special provision may be made for mature applicants, those who are at least 23 years of age, but to be eligible for admission such applicants must have obtained standing in the language and two science subjects.

At present, nursing subjects in both programs are taught in English with opinions for written work in French. Most courses in arts, humanities, and sciences are taught in both languages; nursing students follow these with the

students in other faculties.

Following the recent appointment of a coordinator of continuing education, the school plans to make nursing courses available through university extension, to conduct workshops and seminars, and to offer short programs in clinical and functional areas of nurs-

Yolande Fournier is Dean of the

School of Nursing.

### Queen's University

Queen's .University school of nursing in Kingston, Ontario, offers an inte-grated curriculum for basic students leading to a bachelor of nursing science degree. Admission to a separate program for graduate nurses has been discontinued.

Students in nursing study basic sciences and humanities with students from other faculties in the university. They have representation on the university senate and in the Alma Mater Society.

The school of nursing, utilizing the

resources of the university and community, offers learning experiences and guidance to enable qualified students to design, implement, and evaluate nursing action based on a scientific rationale; to become active participants in the health team; and to become involved citizens in a democratic society. The nursing courses focus on nursing and health needs of people in the community, as well as in an agency setting. The curriculum provides a flexible approach to learning that enables students to observe and participate in the health care of an individual or family.

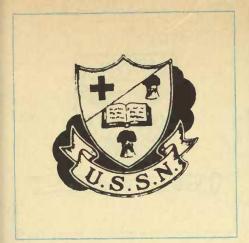
Graduates should be capable of establishing collaborative ralationships with other members of the health team; developing relationships with patients and families that enable them to achieve their maximum health potential and respect their right to self-determination and independence. They should have beginning skill in assessing the capacity of nursing colleagues and in providing guidance to aid them in achieving their maximum potential in giving care to

patients.

Admission requirements are a minimum of 60 percent in a full year of academic work in Grade 13 or equivalent, including chemistry and mathematics. Personal interviews are highly desirable. The current enrollment is

165 full-time students.

Dr. Jean Hill is Dean of the School of Nursing.



#### University of Saskatchewan

The University of Saskatchewan has two campuses, one in Saskatoon and one in Regina. The school of nursing is on the Saskatoon campus, a 3,200acre site on the bank of the South Saskatchewan River.

The baccalaureate program (B.S.N.) for high school graduates is a four-year, integrated course. Clinical experience is provided in University Hospital and in various branches of community health agencies in the city and province. Graduates are prepared for first-level positions in hospitals and public health

agencies.

The baccalaureate program for registered nurses requires the equivalent of three academic years above the R.N. At least one year, the final one, must be spent in full-time study on campus, but part-time study, summer sessions, night classes, and correspondence courses permit graduates to plan according to their own work and personal requirements. The program is nonspecialized, although some choice in clinical emphasis is possible. This program also prepares the graduates for first-level positions in public health nursing.

One-year diploma courses for registered nurses are not likely to be offered

after the 1972-1973 session.

Entrance requirements are based on Saskatchewan Grade 12 — senior matriculation — or its equivalent. Specific high school subjects are also required. The school admits about 100 students yearly to the degree courses. Admissions include men and married women. Nonmatriculated adults who are Saskatchewan residents are also considered under special admission if requested. Students in the school of nursing participate actively in campus life and may live in university residences.

Students should enquire about ad-



mission and complete application forms as early as possible in the year.

Complete information concerning these programs can be obtained by writing to Dr. Lucy Willis, Director, School of Nursing, University of Saskatchewan, Saskatoon, Saskatchewan,

#### St. Francis Xavier University

Founded in 1853, St. Francis Xavier University in Nova Scotia received its charter in 1866. The 28 university buildings are situated in a 200-acre campus near the town of Antigonish.

Through an agreement with St. Martha's Hospital, the university has awarded degrees to nurses since 1926. However, the department of nursing was officially established within the faculty of science of the university in 1966.

The department of nursing offers to qualified high school graduates and registered nurses a program leading to the degree of bachelor of science in nursing. The program is four years, with a minimum of two intersessions, usually scheduled in May and June following the first and second years of the

program.

Entrance requirements include credit in each of the following Grade 12 courses: English, history, mathematics, chemistry; one of biology, physics, another science or a modern language. Graduates of diploma programs may obtain credit in courses in which they can demonstrate knowledge and/or skills in keeping with the objectives of the nursing program at this university. The method for determining the student's eligibility for credit will be decided by the university.

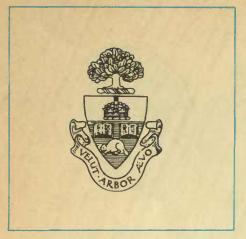
The central focus of the nursing curriculum is the human person approached from the perspective of a

theocentric humanism. Human health, as the core value of the curriculum, is integrated throughout all clinical courses. Clinical courses provide a background of content and experience in family contact, community agencies, and institutional clinical settings to broaden the student's appreciation of the dignity of man, the value of human life, and to assist her to acquire the conviction that nursing practice is a personal service to man in need. In keeping with these values, the nursing curriculum is designed to provide learning experiences that will promote the personal development of the student and enable her to acquire the cognitive, affective, and psychomotor skills necessary for the practice of professional nursing.

The department admits 20 to 25

students per year.

The chairman of the department of nursing is Sister M. Simone Roach, Ph.D. For information write to the Registrar, St. Francis Xavier University, Antigonish, Nova Scotia.



### University of Toronto

Founded in 1920, the University of Toronto school of nursing was first to offer a basic integrated course in which humanities and sciences were related to nursing throughout the course. In 1946 the university first granted its degree to nurses.

In the basic degree course, content in the humanities, social, and biological sciences is given throughout the course, concurrently with the nursing subjects. Nursing is taught around a central core, with concurrent clinical applications in hospitals and health agencies. The program is four years, or 34 months, and leads to a bachelor of science in nursing degree.

Graduate nurses can also enroll for a degree course. The same academic principles are applied in a program that consists of three academic years for graduates of diploma schools of nursing. The first and second years can be taken through the division of univer-

sity extension.

All degree candidates are prepared for public health nursing, teaching, and

supervision.

Ontario Grade 13, with certain prerequisite subjects, is required for admission. However, the admission standards are continually under revision and applicants should write directly to the university for information. Special consideration is given to mature applicants — over 24 years — who may not have had Grade 13 or who have not taken the required high school subjects.

In addition to the undergraduate courses, the school offers a graduate course leading to a master of science in nursing degree. The program is designed to prepare nurses as clinical specialists. Options are available for those interested in teaching or supervision. Each candidate's program is

individually planned in consultation with a faculty adviser, and consideration is given to the individual's interests, potential, and professional goals.

Applicants for the graduate program are considered for admission if they meet the general regulations for admission to graduate studies as outlined by the University of Toronto school of graduate studies, hold a B.Sc.N. degree of the University of Toronto, or an equivalent degree, and have obtained at least second-class standing in each of the final two years.

The school offers a certificate course

in public health nursing.

The school was officially designated the Faculty of Nursing in 1972, and M. Kathleen King is Dean of the Faculty.



### The University of Western Ontario

The faculty of nursing, The University of Western Ontario, is an integral part of the team of health sciences faculties that work in increasingly close cooperation to plan education for all health professionals at Western. Other health educational programs include medicine, dentistry, communication disorders, occupational therapy, and physical therapy.

The health sciences complex includes not only the above faculties, but a well-known cancer research center and a university hospital. The latter, opened in October 1972, adds a vital new dimension, offering a readily accessible and highly specialized clinical field. Other teaching hospitals associated with the university and health agencies in the community are used for student clinical experience in the nursing pro-

grams.

There are currently two programs leading to the B.Sc.N. degree and two programs leading to the M.Sc.N. degree. Graduates of Grade 13 with acceptable standing in certain required subjects enter the four-year basic nursing program. Registered nurses, meeting specific requirements, enter the three-year baccalaureate program for registered nurses. There is special provision for admission of mature applicants, 23 years of age and over. Recognition is given to the background nursing education and experience that the registered nurse brings to her university education.

The purpose of both baccalaureate programs is to prepare professional nurse practitioners who; are capable of assuming beginning professional responsibilities in hospitals and other health agencies; are capable of using further experience to proceed to the assumption of greater responsibility in



#### the practice of nursing; and have a sound educational foundation for proceeding to graduate studies preparing clinical specialists, teachers, administrators, consultants and researchers. All B.Sc.N. students are prepared to

practice nursing wherever it is needed in the community.

The two programs leading to the M.Sc.N. degree include, respectively, a major in administration and a major in teaching. Students entering either program must have an overall B standing in their baccalaureate program. There are specific entrance requirements for each graduate program. The major in administration offers specialization in one of the three following areas: hospital nursing service, public health nursing service, nursing education. The major in education is intended for both beginning and experienced teachers.

The purpose of graduate education in nursing is to prepare graduates to assume senior responsibilities in nursing and to exert wise leadership within the profession of nursing. The programs take into consideration studies satisfactorily completed in undergraduate programs and are designed to build upon the individual's background of education and experience and, where possible, to prepare for individually anticipated responsibilities on graduation.

For particular details relevant to admission requirements and programs, write to: Dean R. Catherine Aiken, Faculty of Nursing, The University of Western Ontario, 1151 Richmond St., London, Ontario, N6A 3K7. For courses in continuing education offered through the summer school and extension department, write to its director,

Angela M. Armitt.

#### University of Windsor

The University of Windsor is situated in Windsor on a large campus bordering the Detroit River. Residences are available for students who want to live

on campus.

In 1955 the department of nursing was created within the faculty of arts and science, and in 1962 it became a separate school. From 1957 to 1967, the school offered a nonintegrated program leading to a baccalaureate degree in which the first and final years were taken at the university. This has now been replaced with a four-year, integrated, basic baccalaureate program that began in September 1968.

The school of nursing presently has three different types of programs. First, it offers a four-year basic program for high school graduates, leading to the bachelor of science honors degree in nursing. This program includes science, arts, and concurrent and yearly terminal clinical practice. The program prepares the graduate for the general practice of nursing in hospitals and health agencies, for team leadership positions, for junior-level teaching positions, and to write the nurse registration examina-

Second, the school offers a baccalaureate degree program for registered nurses who meet university admission requirements, of three academic years or of a shorter duration if courses are taken during summer sessions as well. This program includes preparation for the general practice of public health nursing and introduces the student to the basic principles of teaching and administration. Students may take several of the required courses through the division of extension.

The school also offers a diploma program of one academic year in public health nursing for RNs.

Admission requirements for all programs are Ontario Grade 13 or the University of Windsor preliminary year or equivalent, and must include among other credits English, biology, and chemistry. Registered nurses must be currently registered in a province of Canada. RNs seeking admission under the maturity clause must have completed at least biology, chemistry, and English of Ontario Grade 13 level.

Complete information on each program is contained in the school brochure and the university calendar. As the academic year begins in mid-September, candidates are advised to submit their applications several months in advance and to seek a personal interview. The Director of the School of Nursing is Anna Gupta.

# Street nurses in blue jeans

How four young nurses provided on-the-spot health service to transient youth in the Vancouver area.

Trudi Ruiterman, R.N., B.N., and Gayle Biette, R.N., B.N.

Young people who are transient or part of the counterculture in Vancouver share common health problems: non-medical drug use; unwanted pregnancy; various communicable diseases, including venereal disease; and psychological adjustments to an alienated way of life. However, they often do not seek or obtain health care.

This led to the establishment of the "youth services project," a joint program between British Columbia's health department division of venereal disease control and the Vancouver health department. For the past two years, four nurses have provided a primary health service for these youth.

The "street nurses," as we became known, were required to have a bachelor of nursing degree; be young (under 25 years to eliminate the generation gap); married (to provide stability lacking in the work situation); nonjudgmental; and flexible.

We found that our attitude was the most important factor. How we felt about the kids and their life situation

was communicated nonverbally, thus determining the effectiveness of our care.

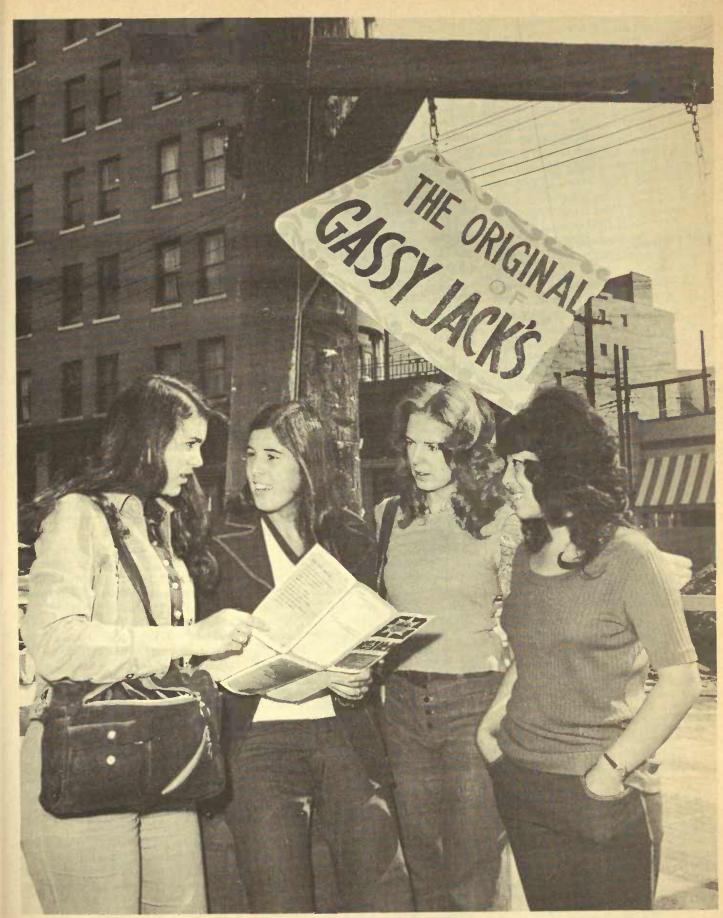
#### Street work and other services

Four areas of Vancouver attracted the kids: West End, East End, Fourth Avenue, and Gastown.\* We each became responsible for one area, frequenting the places where the kids congregated. The communes, head houses, hostels, restaurants, pubs, parks, beaches, rooming houses, and street corners became our "district."

Both our dress and hours were casual

The authors were public health nurses before they became "Street Nurses in Blue Jeans." Ms. Biette recently moved from Vancouver to Toronto. Ms. Ruiterman is now working with the B.C. division of VD control in another capacity.

\* West End: high density, high-rise apartment, and commercial area that merges with downtown Vancouver. Young people live in many of the older low-rental houses situated between apartment blocks. East End: large, multicultural, lower middleclass residential area. Available lowrental housing and anonymity attract youth from Fourth Avenue, West End, and Gastown. Fourth Avenue: Vancouver's original hippie area, with many communal houses and commercial outlets for young people. Gastown: revitalized waterfront area of Vancouver. Many small shops and restaurants make it a popular tourist attraction. Populated by a conglomeration of hippies, young people, drug users and dealers, and tourists.



The "street nurses in blue jeans." Left to right: Sue Johnson, Dianne Symonds, Gayle Biette, and Trudi Ruiterman.

to accommodate the lifestyle of the kids. Wearing blue jeans and packing a suede shoulder bag containing health information and medication, we became walking resource centers. We introduced ourselves with "Hi! I'm the nurse around here. How are you doing?"

Street contact led to contact with kids in the communal houses. Frequent visits made our faces familiar and enabled us to keep pace with the mobility of the kids.

Our on-the-spot service was based on the health needs of the kids. These included contraceptive information and birth control pills, treatment for various communicable skin diseases, prophylactic medication for "the dose," \*\* and advice on upper respiratory infections. Health education and counseling were part of every contact.

As well as street work, each nurse provided services through evening clinics, at the free clinics, health units; and hostels. We worked closely with the free clinics and with the outpatient departments of two general hospitals, often referring kids to them following our initial assessment.

Health problems varied from group to group. The transients traveling during the summer months developed infections resulting from close person-toperson contact. Lice, scabies, ringworm, and colds were common. Immediate assessment, followed by treatment at hostels or crash pads, and the travelers were on their way.

As well as eliminating the need to use expensive hospital outpatient facilities, these visits led to lively discussions about the kids' concerns: vitamins, health foods, drugs (medical and non-medical), philosophy of life, and sexuality. Girls, in particular, had questions about their bodies, their morals, their personal hygiene, vaginal infections, contraception, and venereal disease.

Counterculture youth in a communal setting continually exposed themselves to the "germs of hospitality." Crashers were welcome, but they often inadvertently introduced infections into the house. Three common culprits were

the streptococcal sore throat, infectious hepatitis, and gastroenteritis. As well as taking bacteriological cultures and arranging for treatment, the street nurse rapped with the kids about control of these diseases in relation to their life-style.

The drug user and the year-round transient suffered more from poor nutrition, dental disease, chronic skin infections, serum and infectious hepatitis, and gonorrhea. Health is a low priority when you need a fix, are looking for a trick, or are panhandling for your first meal in three days. This was the most difficult group to work with, because our care could treat only the symptom, not the cause.

#### Reflections of blue jeans nurses

We entered the youth culture with middle-class ideals of work, health, and self-improvement. We had already made our decisions regarding marriage, occupation, sexual values, and future goals but were young enough to identify with the emotional struggles of the kids. Many of them were not only grappling for an identity, but were also forced to make decisions based on a moral code foreign to their background and understanding.

We had our values; so did the kids. Looking back, we were amazingly straight, yet the kids seemed to accept us as we were. The key? We were straight, but bendable.

We realized many situations would not change. A hospital would remain impersonal and efficient. Kids who have a low self-image would react with outbursts of profanity, rudeness, and an energetic desire to become one of the gang. Prostitution, drug abuse, and permissive sex mores remained cold hard facts. We had to adapt our priorities to those of the kids, as each had already chosen his own particular lifestyle.

Carol, at age 16, was a hustler and a speed freak. She could not afford to become pregnant or contract gonorrhea, but had never considered herself at risk for either. Her priority was to earn bread to support her habit; ours became to prevent infection and pregnancy.

Skinny Billy suffered from both speed sores and bleeding gums, two conditions he knew were the direct results of heavy speed use. We were able to provide minimal antibiotic treatment and advice to prevent secondary infection. But the decision to kick the habit was up to him.

Eddie, on another bummer, had been pitching back and forth for the past five hours. He refused to go to emergency because he was there three nights ago and was told never to come back. After consulting the House,† we gave Eddie some Valium (diazepam), which we presumed would be hyped. Fifteen minutes later, Eddie emerged an incredibly sober boy. However, when we left him we did not experience the satisfying feeling that comes from a job well done but, rather, a feeling of dissatisfaction from a job ambivalently done.

Counterculture had its values, so did traditional culture. We who have been trained in the health field often fall into the trap of judging people by their cleanliness and appearance. Consequently, health workers were often hostile toward youth who arrived in bare feet and no underwear. They did not look past the drug problem or the lifestyle of a dude or chick who sought assistance for a specific medical condition.

When these kids were eventually seen, the health workers' expectations for home care and return appointments were usually unrealistic. "Keep warm, eat well, and get lots of rest" was incomprehensible to a transient on the road without any bread. A return appointment for next week would be forgotten if there were better things to do. As far as the transient was concerned, the whole health trip was a hassle. For the health worker, young people were malingerers.

There was a credibility gap between the two cultures. To be effective, we had to reconcile both the "live today" attitude of the young people and the indifferent, sometimes hostile, attitude of middle-class health workers. Inevitably we found ourselves as buffers between the kids and the "establishment." A referral from us to an outpatient department often lent credibility to a transient's desire for medical at-

† The House — a drop-in center for soft

drug users, run by both medical and

paramedical personnel and by volunteers.

<sup>\*\*</sup> A glossary of terms used in this article appears on page 37.

JANUARY 1973

#### Glossary

To express the vibrance and the creativity of youth, we chose to incorporate everyday adolescent jargon. A brief glossary has been provided to explain these various terms. The language of youth, although picturesque, often means exactly what it says.

bread: bummer: chick: crash pad:

money bad experience

girl

a place where one can sleep, usually the home of a recent acquaintance

gonorrhea dose: a fellow dude:

an intravenous injection fix: a mix-up, a bothersome hassle: experience

head house:

a house where young people live, or more often a house where young people who use drugs congregate

deeply involved, heavy: emotional experience

hustler: a young prostitute injected intravenously hyped: kick the habit: break the drug habit panhandle: ask for money on the

discussed rapped:

one who likes to use stimulants, especially the amphetamines

speed sores:

speed freak:

superimposed skin infection as a result of the user scratching areas where speed has collected subcutaneously; irritating, impetigo-like middle class

straight: trick:

sexual relations for the purpose of earning

an experience a person trip: has while under the in-

fluence of a drug, espe-

eially LSD

tention. Interpretation and modification of home care instructions by us enabled the transient to see the logic behind them.

Not only were we instrumental in these situations, but we also acted as buffers between parents and their children. Sandy was a 15-year-old runaway from the U.S.A. Her family had somehow heard of our program and asked us to find her. They wanted to know if she was alright. But Sandy was nowhere to be found.

Judy, on the other hand, had settled in with a group of friends. Even though her concerned father wanted to know her exact whereabouts, he accepted us as his go-between. Because he respected Judy's decision to live on her own, he sent clothes and letters to her, care of us.

#### Contraception

Contraception, a constant request, was never straightforward. We met many girls like Beth. "Listen, you're the nurse, aren't you? I think I need some birth control pills." "I think I need," not "I need" was the subtle catch. Did she really want pills or did she want to discuss her feelings about sex? We often found that girls who were having sexual intercourse had negative feelings about it. Unquestionably there is a lot of pressure to conform.

Beth revealed her many unresolved feelings about sex. She definitely did not want to become pregnant. Considering her recent bout of infectious hepatitis, we discussed why an intrauterine device (IUD) was preferable to the pill. She was referred to a free clinic for the IUD, but in the interim declined the antispermicidal foam because it was just too much trouble.

We felt it was important to inform girls of all available methods of birth control. Many had heard about or had used the pill, some the IUD. The former was usually the method of choice. Many had already decided on the pill because it was seen as the most reliable, most convenient, and the least suggestive of premeditated sex.

Why the program worked

We arrived at three explanations as to why transients did not seek or obtain health care. First, health was definitely a low priority, particularly when one was on the move and broke. Second, there was a lack of understanding by transients and by health workers of each other's values. To use an old cliché, therein lay a communication gap. Finally, the mobility of these young people created the need for on-the-spot services, the coup de maître behind our program.

As primary care workers, we were accepted by the kids because we were at the right place, at the right time, with the right service. And if we did not have the service, we knew where to get it! In other words, our contact and effective action had to be right away or not at all.

A flexible, nonjudgmental attitude was our most important ally. We functioned by assessing priorities and learned early to act on theirs, not ours. We respected the integrity of the kids as we struggled to maintain our own. Who we were was not as important as what we were — the street nurses.

## Intravenous hyperalimentation

Intravenous hyperalimentation provides adequate nourishment for nutritionally depleted patients. It prevents breakdown of body protein in a long-term illness and allows healing to proceed.

Mervyn Deitel, M.D., F.R.C.S.(C), F.A.C.S.

The treatment of most severe diseases of the alimentary tract is surgical. Consequently, malnourished patients in Canada are usually seen on surgical services. Although parenteral nutrition has been progressively improved each decade, sustained and meaningful restoration of the nutritionally depleted patient is a goal that has eluded regular achievement.<sup>1</sup>

Conventional intravenous therapy given postoperatively is adequate to carry a patient temporarily, for example, until a postoperative ileus resolves. However, some weight loss occurs. This means that during a prolonged,

The author, a graduate in medicine from the University of Toronto, is an associate in the department of surgery of the University of Toronto, and a staff surgeon at St. Joseph's Hospital, Foronto. This work was aided by a grant from St. Joseph's Hospital (Toronto) Research Foundation and Abbott Laboratories, Limited. The author thanks the departments of pharmacy, laboratories, photography, and radiology: Tom Petsoulas, technician; and the bedside nurses for their invaluable assistance.

complicated illness with nutritional depletion — major trauma, infection, fistulas, ileus, starvation — a special source of nutrition with adequate calories must be resorted to if the patient is to prevent breakdown of body protein to dangerous levels, and is to heal and survive,2

Intravenous hyperalimentation answers this nutritional need. This therapy is the infusion, into a central vein, of high concentrations of glucose and amino acids for protein synthesis in nutritionally depleted patients.<sup>3,4</sup>

Isotonic solutions, such as five percent dextrose in water, exert the same osmotic pressure as plasma. Solutions infused into peripheral veins are limited to no more than twice isotonicity, because greater concentrations rapidly produce phlebitis in peripheral veins. However, if the markedly hypertonic solutions used in IV hyperalimentation are dripped into the intrathoracic, valveless, large-diameter central veins, the infusion is immediately diluted to isotonic concentration in the large volume of blood,5 enters the heart, and is pumped to the tissues where the nutrients are metabolized without accu-



Figure 1: Infraclavicular route frees patient's arms and neck for movement.

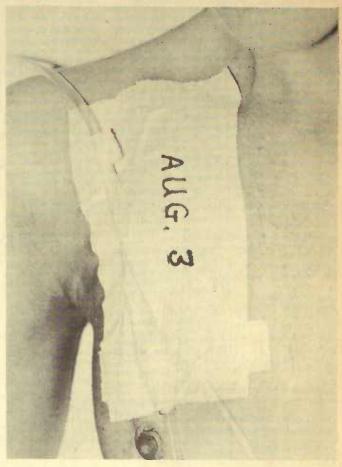


Figure 2: Sterile occlusive dressing secured at the sides with tincture of benzoin.

mulating in the blood. Thus, the osmotic pressure, or osmolality, of the serum does not rise.

For hyperalimentation, the basic requirement of the prescriptions for each bottle of solution is that 150 to 200 calories must be supplied for each gram of nitrogen infused to enter into protein synthesis.6

Nitrogen makes up about 16 percent of the weight of amino acids. Thus, 1 Gm. of nitrogen is equivalent to 6.25 Gm. of protein; 100 Gm. of protein hydrolysate (amino acids) is obtained from hydrolysis of 76 Gm. of protein. The manufacturer fortifies the protein hydrolysates by adding certain amino acids to provide proper ratios of the different amino acids for protein synthesis. Synthetic amino acid preparations may also be used.

If adequate calories are not supplied for the body's energy requirements at the same time that amino acids are

infused, the amino acids themselves will metabolized (deaminated oxydized) for the body's energy needs, instead of being used as building blocks for the synthesis of proteins. Glucose is a suitable source for this energy.7 Since glucose in solution supplies 3.4 cal./Gm., a glucose:animoacid ratio of 5:1 satisfies the above calorie-to-nitrogen ratio.

Technique

At the bedside, with the patient in slight Trendelenberg position with head low to distend the subclavian vein, the shaved skin is defatted with acetone, prepped thoroughly with providone-iodine, and anesthetized with local anesthetic. The doctor performs a percutaneous infraclavicular subclavian puncture, using a 2-3 ml. syringe with a 2" needle.8 When blood is drawn back freely, he removes the syringe and threads in a small plastic catheter and withdraws the needle over the catheter. An infusion is attached.

The infraclavicular route leaves the patient's arms and neck free for movement (Fig. 1).

The catheter insertion site is covered with an antibiotic ointment; the catheter is sutured in place with 3-0 silk; a needle guard is applied to prevent catheter shearing, and a sterile occlusive dressing is secured at the sides with tincture of benzoin (Fig. 2).

Strict sterile technique is mandatory to prevent infection, as the catheters may be required for 30 days, or longer, on one side. The catheter position must be confirmed by an x-ray, as in 25 percent of insertions the catheter takes a malposition, usually up the neck, or occasionally it curls up (Fig. 3).9

In infants under five kg., a very fine catheter is inserted by a cutdown into the external or internal jugular vein. The catheter is threaded to the superior

vena cava and tunneled out through a stab wound in the parietal scalp, where asepsis may be maintained away from the baby's oral and nasal secretions (Fig. 4).10 This procedure is done in the operating room.

#### Solutions individually prescribed

The doctor uses a duplicate order form for solutions — a pharmacy copy and a carbon chart copy. The pharmacy staff prepare the solutions in a clean work station in the hospital pharmacy, using an essentially closed transfer system. 11,12 Although our studies showed that this produced sterile solutions. preparation in a laminar-flow, filteredair hood was begun a year ago. As these solutions are excellent culture media for bacteria and fungi, all additions to them are made in the pharmacy. 13 Special labels detailing contents are affixed to each bottle, and each bottle for any one patient is numbered consecutively to avoid errors. The bottles are stored in the refrigerator until used.

#### Care used

Nurses take extreme care to prevent contamination when attaching the IV tubing to each bottle. A three percent hexachlorophene hand scrub is done, and the bottle top is swabbed with 70 percent alcohol before the administration-set spike is inserted. Our solutions are prepared in two-liter bottles, 15, 16 to reduce frequency of changing, and the chance of contamination during bottle changes.

These solutions must be infused at a constant rate for maximum metabolic efficiency, and the rate of flow must not exceed what is ordered. Too rapid infusion will elevate blood glucose above the renal threshold, causing loss of glucose in the urine, accompanied by electrolytes and water, with resultant dehydration and lassitude. Should the solution be infused too slowly, the nurse does not speed up the IV to "catch up." Instead, the constant prescribed rate is resumed.

A strip of tape beside the scale of the bottle, marked off at levels, may help in checking accuracy of the rate of flow. The calculated drops per minute should also be checked frequently. With a gravity drip, the rate varies when the patient changes position. Our nurses prefer an external-action, constantinfusion Holter roller pump as it assures an accurate delivery rate (Fig. 5), but they still make sure the pump is delivering the prescribed volume of fluid.

The bottles are changed when 100 cc. of solution remain. This is to ensure that the bottles will not run dry and that air will not be pumped in. Micropore membrane filters (0.22 micra) would prevent air embolism and block passage of any bacteria, but some workers have suggested that organisms may concentrate and proliferate on the filter and be discharged with filter damage.<sup>17,18</sup>

We generally do not use filters. However, for infants in whom 130 cc/kg/day are infused to provide 125 cal/kg/day, a 0.22 micra final filter, attached to the central catheter, and a pump are necessary, 19.20 because of the slow, almost stagnant, flow in which bacteria could proliferate (Fig. 4).

Collapsible plastic bags would also avoid air embolism.

An organized team, wearing masks and sterile gowns, and using strict aseptic technique, change the dressings every Tuesday and Friday, or when soiled. An IV hyperalimentation cart contains the necessary equipment for dressings and catheter insertion.<sup>21</sup> The nurse makes sure equipment is available, helps the orderly progress of the procedure, and alerts the doctor to possible breaks in technique.

Meticulous care is the only way to assure safe, long-term use of this catheter. We have had no problems from changing the IV tubing only once every seven days, but it is changed whenever there is suspicion of contamination, for example, during changing of bottles. Final removal of the catheter is done by the doctor.

Patients are encouraged to move and to walk about. Optimal nutrition requires activity, otherwise protein catabolism and "body atrophy" result. To prevent the occurrence of shearing and catheter-embolism to the heart, there must be no traction on the catheter

These patients also require psychological support.

Electrolytes, blood sugar, and BUN are drawn every Monday, Wednesday, and Friday. Later, as the replacement is stabilized, these chemistries are drawn at broader intervals. Urine is checked for sugar four times daily, every six hours if possible, and coverage

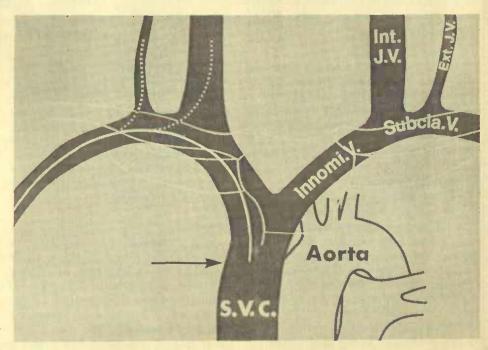


Figure 3: Arrow points to proper site of catheter tip. Dotted lines indicate catheter up neck. Int. J.V. (internal jugular vein), Ext. J.V. (external jugular vein), Subcla. V. (subclavian vein), Innomi.V. (innominate vein), S.V.C. (Superior vena cava).

with insulin is given for 4+ only. A urine sugar of less than 4+ corresponds to an acceptable loss of less than 2 Gm. of glucose/100 cc. of urine. Urine is generally negative for sugar. However, diabetics, those on high doses of steroids, and those with sepsis have glucose intolerance and require coverage with regular insulin. Patients are weighed twice weekly on an accurate bed-scale.

IV hyperalimentation is carried out at the bedside in the wards, private rooms, intensive care unit, or infectious unit. A special unit is neither necessary nor desirable for this treatment, as the patients also require care related to the area from which they are referred. The number of patients on this treatment has varied from one to nine at any one time.

#### **Precautions**

The dressing must be kept intact. Catheter shearing must not occur. Aseptic technique is mandatory.<sup>22</sup> <sup>23</sup>

Blood, plasma, antibiotics, digoxin, etcetera, are not given through the subclavian line, as this could invite contamination of the system. When necessary, they are administered through a peripheral IV. Furthermore,

the central catheter is not used as a source for drawing blood.

A sudden temperature elevation should be reported immediately to the doctor in charge of hyperalimentation. If a cause for the elevated temperature cannot be found, the bottle and tubing should be changed and cultured. If fever persists, the doctor will remove and culture the catheter and have a blood culture done.

The proper flow rate must be maintained. Urine should be checked for sugar. Dehydration and lassitude should be watched for. Pain and swelling (inflammation) of the neck, shoulder, arm or chest wall must be reported.

#### Our patients

In our experience, hyperalimentation was used in three groups: those unable or unwilling to eat; those in whom elimination of oral intake would improve the problem; and, with omission of the protein hydrolysate, those in acute renal <sup>24</sup> or hepatic <sup>20</sup> failure, (*Table I*).

Patients, whose ages ranged from 4 weeks to 94 years, were on hyperalimentation an average of 22 days. Eleven patients required hyperalimentation for more than 50 days, 5 for more than 75

days, and 2 for more than 100 days. Of the 11 patients who were 80 years or older, 10 survived and 1 died of her underlying disease. Seven patients died of their disease while on hyperalimentation, but no death could be attributed to this therapy.

Many malnourished patients were infused preoperatively so that they could tolerate an operation, and healed without difficulty as the infusion was continued postoperatively. In seven patients, hyperalimentation was used to afford colonic rest, and thereby obviated the need for a defunctioning colostomy.

Due to careful management by nurses and responsible staff, only two complications arose. One instance of catheter sepsis resolved promptly on removal of the catheter, and the infusion was continued through the opposite subclavian vein. In this patient, *Staph. aureus* was grown on blood culture and culture of the catheter tip. It was interesting that this patient was one of the few who had a micropore filter used in the system.

The second complication was eventual spillage of sugar into the urine, high blood sugar, high serum tonicity, somnolence, twitching, and coma due to intracellular brain dehydration in a latent diabetic. The coma subsided on treatment with large volumes of hypotonic solutions and regular insulin, and hyperalimentation was resumed with a lower concentration of infusate, plus insulin.

#### Clinical findings

Clinical findings included healing of multiple enterocutaneous fistulas, huge abdominal wall defects, and large bedsores. Weight gains of up to 11 kg. per month occurred. Nutritional edema of the legs disappeared. A line of demarcation appeared on fingernails, indicating the day on which hyperalimentation had begun, and the previous poorly formed nails were extruded. Scalp hair and palmar skin were shed and replaced. Patients' alertness and activity increased. Many patients lacked appetite while receiving the nutritional infusion; others, previously too weak to eat, gained strength and appetite.

In nondiabetic patients, serum insulin levels rose abruptly with the high glucose infusions, and the blood sugar

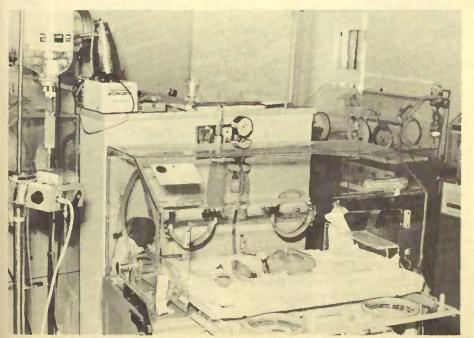


Figure 4: Premature infant, born at 29 weeks weighing 940 Gm., had frequent cyanosis with tube feedings and did not gain weight. At 4 weeks, a silicone rubber catheter was threaded centrally and tunnelled out the scalp to permit hyperalimentation. He gained 270 Gm. in 11 days, matured to tube feedings, and ultimately was normal.

TABLE I

#### Major Diagnosis in Patients on Intravenous Hyperalimentation\*

	No. of Patients
Esophageal Obstructions and Leaks	11
Complicated Gastric Surgery	10
Gastric Outlet Obstruction	15
Post Biliary Reconstructions	3
Pancreatic Fistula	4
Fulminant Pancreatitis	3
Enterocutaneous Fistulas	33
Bowel Obstructions	12
lleitis, Colitis, and Polyposis	7
Short Bowel Syndrome	3
Colonic Perforation or Disruption	5
Closure Rectovaginal Fistula	
Major Wound Disruption and Peritonitis	3
Premature Infant Feeding Problem	1
Liver Failure	5
Renal Failure	1
Others — Cachexia, Debilitation, Chronic Lung Disease	8
	125
	125

\* Complicated Cases

remained within normal range throughout treatment, that is, the pancreatic insulin response did not become exhausted.<sup>26</sup>

The following report on a 59-yearold woman shows the results. She had had multiple abdominal operations, including removal of the gallbladder and excision of the left colon. On March 1, 1970, she underwent total colectomy and ileostomy for ulcerative colitis. Postoperatively the patient developed multiple small bowel fistulas, draining liquid stool through her incision and retention suture sites. Oral intake increased the drainage and enlarged the fistulas. Her peripheral veins were closed by phlebitis from repeated IVs. She developed reactive depression.

On March 18, 1970, intravenous hyperalimentation was begun, and the patient was to have nothing by mouth. Her serum proteins rose from 3.7 to 6.3 Gm. (albumin rose from 1.37 to 3.15 Gm.), her fistulas stopped draining in two weeks and closed, she grew new nails, and her weight increased

from 39.2 to 43.0 kg. This occurred over 29 days, and on April 20, hyperalimentation was discontinued.

#### Alternative treatment

An additional 61 patients were given elemental, nonresidue diets. These contain basic chemicals similar to those in the hyperalimentation bottle, with flavoring added to make them palatable. Since they are "predigested," they are ready for absorption and do not stimulate enzyme secretion.

Patients differ in their flavor acceptance. When accepted, the elemental diet may be given as frequent sips to prevent dumping or diarrhea. They may be pumped (similar to IV hyperalimentation) through a No. 5 French nasogastric feeding tube from 8:00A.M. to 10:00 P.M., with the head of the bed elevated to avoid aspiration, or through a gastrostomy tube when aspiration presents a problem.

Healing of fistulas appeared slower with the elemental diets than with IV hyperalimentation, as the latter produces maximal mechanical rest of the

gastrointestinal tract, and the basal outputs of intestinal secretions are actually reduced with IV hyperalimentation.<sup>27</sup>

#### Conclusion

Intravenous hyperalimentation has saved the lives of patients who undoubtedly would have died with conventional treatment. It is a major breakthrough in the care of the nutritionally depleted patient who is unable to eat. Any hospital that accepts the responsibility for handling major medical, surgical, or traumatic illnesses should have informed nurses and a competent, team to handle this procedure. <sup>28,29</sup>

#### References

- 1. Dudrick, S.J. et al. Can intravenous feeding as the sole means of nutrition support growth in the child and restore weight loss in an adult? An affirmative answer, *Ann. Surg.* 169:6:974-84, Jun. 1969.
- 2. Rush, B.F. Jr. et al. Positive nitrogen balance immediately after abdominal operations. *Amer. J. Surg.* 119:1:70-5, Jan. 1970.



Figure 5: Patient with history of regional ileitis treated with hyperalimentation and total bowel rest while fecal fistulas healed. Solution delivered by a small pump, which may be battery-operated to allow patient mobility.

- 3. Dudrick, S.J. and Rhoads, J.E. Total intravenous feeding. Sci. Amer. 226: 5:73-80, May 1972.
- 4. See reference no. 1
- 5. Deitel, M. A system of intravenous hypersomolar alimentation. Excerpta Medica. (In press.)
- 6. Larsen, V. and Brockner, J. The value
- of parenteral nutrition in patients with gastro-intestinal diseases. Scand. J. Gastro. 4: Suppl. 3:41-7, 1969.
- 7, see reference no.3
- 8, see reference no.1
- 9. Deitel, M. and McIntyre, J.A. Radiographic confirmation of site of central venous pressure catheters. Can. J.

- Surg. 14:1:42-52, Jan. 1971.
- 10. Dudrick, S.J. et al. Long-term venous catheterization in infants. Gynec. Obstet. 129:10:805-8, Oct. 1969.
- 11. Sauvé, F., Sr. The pharmacist and a nutritional intravenous therapy program. Amer. J. Hosp. Pharm. 28:2: 106-9, Feb. 1971.
- 12. Sauvé, F., Sr. The preparation of solutions for hyperalimentation. Canad. J. Hosp. Pharm. 25:60-2, Mar./Apr. 1972.
- 13. Sanderson, I. and Deitel, M. Hyperalimentation without sepsis. Surg. Gynecol, Obstet. (In press.)
- 14. see reference no.13
- 15, see reference no.11
- 16. Deitel, M. et al. A system of intravenous hyperalimentation. (Submitted for publication.)
- 17. see reference no.13
- 18. Atkins, R.C. et al. The artificial gut in hospital and home. Technical improvements. Trans. Amer. Soc. Artif. Intern. Organs 26:260-6, 1970.
- 19. see reference no.10
- 20, see reference no.16
- 21. Deitel, M. and Sarson, A. An intravenous hyperalimentation cart. Surg. Gynecol. Obstet. 133:12:1017-8, Dec. 1971.
- 22. Curry, C.R. and Quie, P.G. Fungal septicemia in patients receiving parenteral hyperalimentation. New Eng. J. Med. 285:22:1221-5, Nov. 25, 1971.
- 23. Boeckman, C.R. and Krill, C.E. Bacterial and fungal infections complicating parenteral alimentation in infants and children. J. Pediat. Surg. 5:117-126, Apr. 1970.
- 24. Dudrick, S.J. et al. Renal failure in surgical patients: treatment with intravenous essential amino acids and hypertonic glucose. Surgery 68:7:180-6, Jul. 1970.
- 25. Dudrick, S.J. and Rhoads, J.E. New horizons for intravenous feeding. JAMA 215:939-49, Feb. 8, 1971.
- 26. Sanderson, 1. and Deitel, M. Insulin response in patients on prolonged intravenous hyperalimentation. Surgical Forum. 23:64, Oct. 1972.
- 27. Hamilton, R.F. et al. Effects of parenteral hyperalimentation on upper gastrointestinal tract secretions. Arch. Surg. 102:4:348-52, Apr. 1971.
- 28, see reference no.13
- 29, see reference no.16

### dates

#### January 22-26, 1973

Five-day workshop on "Bridging Gaps in Community Nursing Care," school of nursing and extension division, University of Saskatchewan. The workshop will focus on ways to improve nursing services in our communities. All senior nursing personnel are invited to attend. Registration fee: \$35. For further information, write to: Ms. Norma Fulton, Continuing Nursing Education, U. of Saskatchewan, Saskatoon.

#### January 26-27, 1973

Evaluation of Learning Outcomes, Unit IV, Auditorium, Canadian Arthritis and Rheumatism Society. University of British Columbia program to provide nurse instructors with knowledge of techniques to evaluate learning outcomes in terms of clinical nursing. Fee: \$40. For further information, write to: Continuing Education, P.A. Woodward Instructional Resources Centre, Vancouver 8, B.C.

#### February-March, 1973

Workshops on "Care of the Normal and High Risk Newborn," University of Saskatchewan, Saskatoon. Dates of these workshops are as follows: February 6, 1973 — evening workshop on "Care of the Normal Newborn." February 15, 1973 — all-day workshop on "Intensive Care of the Neonate." Resource person: Dr. Gordon Peirie, Assistant Professorof Pediatrics, Vancouver General Hospital. Vancouver. February 20, February 27, March 6, 1973 — evening workshops on "Problems of the Newborn." For further information, write to: Ms. Norma Fulton, Nursing Continuing Education, University of Saskatchewan, Saskatoon,

#### February 8-11, 1973

Canadian University Students' Association conference, Dalhousie University, Halifax, Nova Scotia. Conference theme: "The Community."

#### February 9-10, 1973

Two-day course on "Nursing Care Plans," Auditorium, Canadian Arthritis and Rheumatism Society. University of

British Columbia program to enable nurses to use nursing care plans more effectively. Fee: \$30. For further information, write to: Continuing Education, P.A. Woodward Instructional Resources Centre, Vancouver 8, B.C.

#### February 12 - March 23, 1973

Intensive care nursing program, Fanshawe College, London, Ontario. Preference will be given to candidates who are subsidized by a hospital, have at least one year's experience, and who work in an ICU. For further information, write to: Intensive Care Nursing Program, Director, Fanshawe College, Health & Welfare Div., Box 4005, Terminal C, London, Ontario.

#### March 13-16, 1973

University of British Columbia course in maternal health and pediatric nursing, Auditorium, Canadian Arthritis and Rheumatism Society. Program will enable nurses practicing in hospital and community settings to update clinical knowledge and skills. Fee: \$55. for 4 days; \$30 for 2 days. For further information, write to: Continuing Education, P.A. Woodward Instructional Resources Centre, Vancouver 8, B.C.

#### March 16-17, 1973

Two-day symposium/workshop on "Epilepsy '73: A Multidisciplinary Symposium on C u r r e n t Developments," David Whitney House, Detroit, Michigan. For further information, write to: Epilepsy Center of Michigan, 10 Peterboro, Detroit, Michigan 48201, U.S.A.

#### April 12, 1973

Canadian Nurses' Association, annual meeting, Chateau Laurier Hotel, Ottawa, Ontario.

#### April 11-12, 1973

"Continuity of Health Care in B.C.," Harrison Hotel, Harrison Hot Springs, B.C. This course — for directors of nursing and senior administrative personnel — is planned in cooperation with the nurse administrators section,

Registered Nurses' Association of British Columbia. Fee: \$50. For further information, write to: RNABC, 2130 W. 12th Ave., Vancouver 9, B.C.

#### May 7-11, 1973

Postgraduate course in childbirth education, McGill School of Physical Therapy, Montreal. Sponsored by McGill University. This bilingual program is designed for paramedical personnel interested in the obstetrical field. Registration fee: \$50. Application forms available from: Ms. C. Morse, 73 Dunrae Ave., Mount Royal 304, P.Q.

#### May 13-16, 1973

Workshop on Evaluation of Student Nurse Clinical Performance, sponsored by The University of Western Ontario, London. Instructor: Professor Vivian Wood. Tuition fee, including accommodation and meals: \$125. For further information, write to: Summer School and Extension Dept., U. of Western Ontario, London 72, Ontario.

#### May 13-19, 1973

International Council of Nurses, 15th Quadrennial Congress, Mexico City.

#### May 14-15, 1973

Third annual conference, Alumni Committee, Faculty of Nursing, University of Western Ontario. Symposium on "Understanding and Helping the Family in Modern Society" to be led by Dr. Norman Bell, Professor of Sociology, U. of Toronto. For further information, write to: Ms. Mary Gee, Publicity Chairman, 206 St. James St., London, Ontario. N6A 1W8

#### May 14-17, 1973

Operating Room Nurses of Greater Toronto, second national conference for operating room nurses in Canada, Skyline Hotel, Toronto, Ontario. Simultaneous translation will be available. Direct enquiries to: Ms. Jean K. Watson, Convenor, Publicity Committee, 3 Du Maurier Blvd., Apr. 111, Toronto 319, Ontario.

#### 44 THE CANADIAN NURSE

### names

Louise McIntyre has been appointed associate employment relations officer for the New Brunswick Nurses Provincial Collective Bargaining Councils.

A native of Moncton, Ms. McIntyre is a 1971 graduate of the University of Moncton School of Nursing. Prior to accepting her new position in September 1972, she worked as a general staff nurse at Docteur Georges L. Dumont Hospital in Moncton.

Ms. McIntyre's duties include assisting employment relations officer Glenna Rowsell in the administration of a collective bargaining program for the bargaining councils. She replaces Grace Stevens, who retired from her position in 1972.



Lorraine Bourque (B.N., Dalhousie U., Halifax, N.S.; M.Ed., U. of Ottawa, Ontario) joined the test development staff of the Canadian Nurses' Association Testing Service in May 1972 as a test-

ing specialist.

Ms. Bourque came to Ottawa from Fredericton, New Brunswick, where she worked for the New Brunswick Department of health as a public health nurse for eight years and on the faculty of nursing at the University of Moncton for two years. She has also worked as an occupational health nurse for Bell Canada in Toronto and has done obstetrical nursing in Alberta.

The following appointments have been made to the nursing department of Grant MacEwan Community College in Edmonton, Alberta. The college opened in the fall of 1972.



Thérèse Castonguay, s.g.m. (R.N., St. BonifaceH., Manitoba; B.S.N., U. of Montreal; M. S.N., Catholic U. of America, Washington, D.C.) was appointed chairman of the nursing depart-

ment in September 1971. Sister Castonguay has had wide experience in

U Of A Students Win Canadian Liquid Air Awards



The two top first-year students in the University of Alberta's health services administration program were honored at a dinner at the university's faculty club in November 1972. Ronald Douglas Taylor, Calgary, center, won the Canadian Liquid Air Limited \$1,000 award. He attained the highest academic standing in the administration program. Beside him is Grace M. Johnston, Ottawa. As the student with the second highest academic standing, she was presented with a \$500 cheque, At the left is Carl A. Meilicke, Ph.D., director of the university's division of health services administration.

clinical nursing, nursing service administration, teaching, and nursing education administration.

Ellen Martin, s.j. (R.N., St. Joseph's H., Lewistown, Montana; B.S.N. and M.S.N., Catholic U. of America) is clinical coordinator of the nursing program. She has had a varied background in teaching, nursing education administration, and hospital administration. Before her new appointment she was director of nursing education at Edmonton General Hospital, Edmonton, Alberta. Sister Martin is president of the Catholic Hospital Conference of Alberta.

Norma Young (R.N., St. Boniface H., Man.; B.N., U. of Manitoba, Winnipeg) is section head for the first year of the college's nursing program. She has had experience in clinical nursing and has taught nursing fundamentals and medical-surgical nursing.

Pat Picketts (R.N., Calgary General H., Calgary, Alta.; B.Sc.N., U. of

Alberta) is section head for the second year of the nursing program. She has had experience in clinical nursing and as a teacher of medical-surgical nursing.

Rhea Arcand (R.N., Misericordia H., Edmonton; B.Sc.N., U. of Alberta), instructor, has had experience in clinical nursing and has taught fundamentals of nursing and medical-surgical nursing.

Danin Bodnar (R.N., Edmonton General H.; B.Sc.N., U. of Alberta), instructor, has had experience in clinical nursing and has taught nursing fundamentals and maternal and child health.

Betty Davies (R.N., U. of Alberta H., Edmonton; B.Sc.N., U. of Alberta), instructor, has had experience in clinical nursing and has taught pediatric nursing.

Paulette Falconer (R.N., Edmonton General H.; B.Sc.N., U. of Alberta), instructor, has had experience in clinical nursing, public health, and teaching psychiatric nursing.

#### names



Sr. Ellen Martin



Norma Young



Pat Picketts



Rhea Arcand



Danin Bodnar



Betty Davies



Paulette Falconer



Cheryl Hoffmeyer

Cheryl Hoffmeyer (R.N., Regina Grey Nuns' Hospital; B.Sc.N., U. of Alberta), instructor, has had experience in clinical nursing and has taught nursing fundamentals and maternal and child health.

Emily Knor (R.N., U. of Alberta H.; B.Sc.N., U. of Alberta), instructor, has worked in clinical nursing, as a head nurse, and has taught medical-surgical nursing

Jenneice Larsen (R.P.N., Alberta H., Edmonton; R.N., Misericordia H., Edmonton; B.Sc.N., U. of Alberta), instructor, has had teaching experience in psychiatric nursing, nursing funda-

mentals, and medical-surgical nursing.

Myrna Maquera (B.Sc., U. of St. Thomas, Manila, Philippines; graduate studies in midwifery, Philippine Women's U.; postgraduate course in pediatric nursing, Bronx Municipal Medical Center, New York), instructor, has taught nursing fundamentals, maternal and child health, and medical-surgical nursing.

Donna Patching (R.N., U. of Alberta H.; B.Sc.N., U of Alberta), instructor, has had experience in clinical nursing and has taught nursing fundamentals, maternal and child health, and psychiat-

ric nursing.

Bernice Stiansen (R.N., Holy Cross H., Calgary; diploma in teaching and superv., U. of Alberta), instructor, has taught nursing sciences, fundamentals of nursing, maternal and child health, and medical-surgical nursing.

Jennie Wilting (R.N., Blodgett Memorial School of Nursing, Grand Rapids, Michigan; U. of Minnesota, Minneapolis), instructor, has worked in clinical nursing and as an instructor in medical-surgical nursing. After working as a head nurse, she taught psychiatric nursing in diploma and baccalaureate nursing programs. More recently, she was a consultant for teachers of



Emily Knor



Jenneice Larsen



Myrna Maquera



Donna Patching



Bernice Stiansen



Jennie Wilting

#### MOVING? BEING MARRIED?

Re sure to notify us six weeks in advance, otherwise you will likely miss copies.

Attach the Label
From Your Last Issue
OR
Copy Address and Code

NEW (NAME) /ADDRESS:

Street

City Zone

Prov./State Zip

Please complete appropriate category:

I hold active membership in provincial nurses' assoc.

reg. no./perm. cert./ lic. no.

I am a Personal Subscriber.

MAIL TO:

The Canadian Nurse

50 The Driveway

OTTAWA, Canada K2P 1E2

psychiatric nursing and taught in the continuing nursing education program offered by the school of nursing at the University of Alberta.

Edith Vivian Benoit (B.N., U. of Manitoba; M.Sc.N., U. of Western Ontario, London) has been appointed an assistant professor at the University of British Columbia school of nursing in Vancouver. She is teaching medical-surgical nursing.



A native of Winnipeg, Ms. Benoit has worked as a staff nurse and nursing teacher at The Winnipeg General Hospital. She was a Canadian Nurses' Foundation scholar in 1971.

McMaster University School of Nursing in Hamilton, Ontario, has announced the following appointments.

Margaret Bennett, B.S.N., M.Sc., is an assistant professor responsible for teaching psychiatric-mental he alth nursing in year III. For several years, she was a member of the faculty of the University of Hawaii School of Nursing.

She recently spent a year with the Hamilton Civic Hospital School of Nursing in Hamilton, Ontario.

Mary Buzzell, B.N., M.N., M.Ed., is an assistant professor responsible for directing the educational program for family practice nurses. She is experienced in medical-surgical nursing and in adult education.

Sheila Delaney, B.Sc.N., is a lecturer on loan from the Chedoke-Mc-Master Centre for the academic year to assist in teaching psychiatric-public

health nursing in year IV.

Kay Harrison, B.Sc.N., M.S., is an assistant professor. She has had wide experience in community mental health as a practitioner, consultant, and teacher. She will teach psychiatric-mental

health nursing in year III.

Dr. Ruth MacKay, B.A., M.N., M.A., Ph.D., is an associate professor responsible for teaching and coordinating senior nursing in year IV of the curriculum. She will also devote time to planning and implementing the proposed program leading to the degree of Master of Health Sciences (health care practice).

Betty Oka, B.Sc.N., M.N., is a parttime lecturer. Ms. Oka is experienced in medical-surgical nursing, primarily coronary care. Recently she worked with a children's aid society, and has been involved in assessment and development of foster families. She has joined the year I team.

Ruth Pallister, B.S.N., M.N., is an assistant professor, responsible for teaching and coordinating the year IV courses in psychiatric nursing and public health nursing. Ms. Pallister attended the University of Washington as a

Laidlaw Foundation Fellow.

Joan Royle, B.Sc.N., M.Sc.N., is a lecturer. Ms. Royle has joined the year III team, where her primary focus will be teaching medical-surgical nursing. She has been employed in community nursing and has had teaching exper-

Marilyn Steels, B.Sc.N., M.N., is a lecturer in medical-surgical nursing on the year II team. She has worked with the Victorian Order of Nurses, Hamilton-Dundas, Ontario branch. Ms. Steels attended Case Western Reserve University in Cleveland, Ohio, as a Canadian Nurses' Foundation Fellow.

Mary Lou Ware, B.N., is a lecturer in year II. She has had considerable experience in pediatrics as a practition-

er and as a teacher.

May Yoshida, B.Sc.N., M.N., is a part-time associate professor with a primary responsibility to the family practice nurse practitioner educational program. Ms. Yoshida has been associated with McMaster as a research associate for the Nurse Activity Study and related projects.



#### Tucks\*

offer prompt, temporary relief from the discomforts of itching, burning and irritation associated with hemorrhoids, post-operative anorectal surgery wounds and episiotomies. Used as a compress, they relieve itching and edema with a cooling, mildly astringent action. As an after stool wipe, Tucks gently and thoroughly cleanse while soothing tender, traumatized tissues. Moist, soothing Tucks are soft disposable flannel pads saturated with Witch Hazel (hamamelis water) 50%, Glycerine, U.S.P., 10%, Purified Water, U.S.P., de-ionized, q.s. buffered to approximate pH of 4.6: They come in jars of 40 pads. Ready prepared Tucks can be kept by the patient's bedside for immediate application whenever their soothing, healing properties are indicated.

#### Fuller Shield\*

Protective dressing to hold anal, perianal and sacral dressing comfortably in place; prevent soiling of clothing or linens with wound drainage, watery fecal leakage, staining medications. Does not bind. No tape needed. Fits male or female patients, waist sizes 24 to 48. Order two per patient; one to launder while other is worn.

For clinical trial supply write to:



ICN Canada Ltd.

675 Montée de Liesse, Montreal 377, P.Q.

M-2897

\*Trade marks of Fuller Laboratories, Inc.

### books

Paramedical Pathology: Fundamentals of Pathology for the Allied Medical Occupations by Alvin F. Gardner. 200 pages. Springfield, Illinois, Charles C. Thomas, 1972. Reviewed by Dianne Bloor, Teacher, Ottawa Civic Hospital School of Nursing, Ottawa, Ontario.

In the preface of this text, the author identifies the 15 paramedical groups for whom this book was designed. This list encompasses such diverse occupational groups as registered nurses, medical record librarians, and histologic technicians. The text is intended "to provide the members of the allied health teams with the basic science fundamentals of pathology" that may be used as a basis for future study in their particular occupation.

The book defines pathological terms, presents information on pathological changes resulting from various stressors, and describes the pathology of

numerous systemic diseases.

Although all 200 pages of this text are well packed with current information, the varied population to which it is directed means that much material is irrelevant for nursing students and practitioners. For example, descriptions of cellular and tissue changes are too detailed for nurses.

An attempt is made to describe broad principles; this is best achieved in a chapter dealing with inflammation, repair, and regeneration. Nevertheless, little time is spent on general body response to disease in comparison to the time devoted to specific reactions and diseases. For example, the causes of edema are enumerated in two short paragraphs, and little information regarding general allergic reactions is presented.

On the other hand, a relatively large proportion of material is devoted to a detailed description of the sequence of the clotting mechanism and to pathological conditions accompanying disease states. Many of these, such as Gaucher's disease and scleroderma, are rarely seen by the average nurse. All parts of the text are steeped in pathological terminology.

There are, however, several redeeming features. The numerous photographs provide excellent visualization of theory presented. Tables are generally uncluttered, easily understood, and used

effectively both to provide summaries and introduce new material. The inclusion of clinical diagnostic tests with the related pathology is also of value.

A comprehensive index is included, which brings information quickly to the fingertips, and gives it value as a reference text. Users of this book would require a thorough knowledge of normal anatomy and physiology.

Autotutorial Techniques in Nursing Education by Crystal M. Lange. 105 pages. Englewood Cliffs, N.J., Prentice-Hall, 1972. Canadian Agent: Prentice-Hall of Canada, Toronto. Reviewed by Betty McInnes, Coordinator of Learning Resources Centre, St. Joseph's School of Nursing, Hamilton, Ontario.

This book is designed for nurse educators who are interested in making learning experiences as easy and effective as possible. The learning experiences presented are patterned after Dr. Postlethwait's approach to education with modifications to meet the needs of nursing education. This approach continually emphasizes the role of the student in the learning process.

The author states that the autotutorial approach equates achievement of specified objectives with learning rather than time with learning. That is, when the student has demonstrated attainment of objectives, he has completed the required learning. The time it takes a single student to achieve the objectives will be specific to that student. However, this objective is only partially met in this curriculum approach, as time is still the governing factor.

In this curriculum it seems the student must be ready to demonstrate achievement of objectives at specific times determined by the teachers in each week of the curriculum, and if they are not ready, they are penalized either with poor grades or exclusion from a clinical experience. These are the same types of penalties that apply in any standard curriculum that does not consider the individuality of students, and so the idea of equating achievement to learning is defeated time is still the all-important element. The time it takes a single student to achieve the objectives is not specific to the student, but rather to the time elements of the curriculum.

The book is basically divided into four topics: autotutorial approaches, environmental design, faculty team,

and student performance.

The latter section includes a week's unit of study. The autotutorial approaches in the curriculum design uses, with some modifications, Dr. Postlethwait's four basic sessions: the independent study session, which has been renamed in the nursing curriculum the autotutorial laboratory; the general assembly session; the small assembly session; and the integrated quiz session.

A fifth session has been added to the original concept and that is the clinical laboratory session. Each of these sessions is discussed in detail. The section on environmental design of an autotutorial laboratory includes information on size and number of carrels per student ratio, basic equipment required, exhibit areas, practice area, environmental controls, storage, hardware and software requirements, and use and staffing of the area.

The sections on the faculty team and student performance could be enlarged. The book would be improved if more depth in discussion were included on the increased guidance required by students using this approach. Also, the new role of the teacher is virtually ignored. All the physical planning of facilities, services, and programs are discussed and emphasized by examples, but the change in philosophy that each teacher must undergo, accept, and

#### NURSING STUDIES INDEX

Addendum number four of the Canadian Nursing Studies Index is now available. This addendum covers studies received in the CNA repository collection, or reported, in 1971-72.

Automatic distribution has been made to holders of the basic index. Any person who did not receive the newest addendum and who wants a copy may write to the Canadian Nurses' Association library, 50 The Driveway, Ottawa, K2P 1E2. The index is available without charge to libraries and research workers.

internalize to make this approach successful is barely touched on.

In summary, the author has provided for nurse educators an interesting concept and approach to learning, one in which the role of the student is continually emphasized.

I would recommend this book for nurse teachers to use as a beginning guide to the autotutorial approach in nursing education, with the reservation that more research could be pursued.

The Retarded Child and His Family by John B. Fotheringham, Mora Skelton and Bernard A. Hoddinott. 115 pages. Toronto, Ontario Institute for Studies in Education, 1971.

Reviewed by Harold Robbins, M.S.W., Staff Member, Mental Retardation Services Branch, Ontario Ministry of Health, Toronto, Ontario.

This book is the result of a study of the relative merits of keeping retarded children in the home or admitting them to an institution. Changes in the functioning level of children and parents in the two groups were observed over one year.

The chapter on method outlines the choosing of a study sample and describes the measures and techniques used to ascertain before and after functioning levels. This is followed by chapters describing preadmission characteristics, areas of concern and reasons for admission, and functioning changes that took place over the study period. These are succinctly written and offer a clear picture of the methodology followed.

Conclusions are reserved for chapter six, which outlines the general conclusion that there were no significantly different changes in the functioning of the retarded children in the two different situations, together with a number of related findings such as: families who had their children admitted to an institution did not improve significantly in terms of measured levels of family functioning; the intellectual functioning of both the institutionalized and community-based children decreased over the study period; C.A.S. children admitted to institutions were older, brighter, and possibly less troublesome than those admitted from their own homes

The final chapter suggests that home and institution should not be considered as alternatives, but as opposite ends of a spectrum of living situations that may be considered appropriate for retarded persons. These include supplementary home care with community services and replacing, where necessary, home living with community residences.

Tabular and graphic presentations of

the data, together with an outline of the family functioning scale used, are included in the appendices of the book.

Fundamentals of Patient-Centered Nursing, 3ed., by Ruth V. Matheney, Breda T. Nolan, Alice E. Hogan, and Gerald J. Griffin. 288 pages. Saint Louis, Mosby, 1972. Reviewed by Jean Leavens, Teacher,

School of Nursing, Toronto General Hospital, Toronto, Ontario.

This is a revised text specifically designed for beginning nursing students. The book is based on fundamental concepts in nursing, rather than on procedures and techniques. A knowledge of anatomy, physiology, social sciences, nutrition and pharmacology is assumed, or to be taught concurrently.

The book is presented in a clear and concise manner and is augmented by numerous photographs and diagrams. The interrelationships of systems and the development of observational skills have been stressed throughout.

The chapter on meeting the religious needs of patients briefly presents the basic beliefs of Judaism, Christianity, Islam, Hinduism, Zen Buddhism, to name a few. This information is pre-

RN.'s

### SPEEDY PLACEMENT IN SUNNY CALIFORNIA

Immediate staff positions to \$904/mo. (\$10,848.a) plus major benefits. Other openings/salary commensurate to education and experience.

U.S. entry & work permit (yearly term) obtainable within 30 days. You do not have to appear at the U.S. Consulate for your visa, Housing accommodations & relocation assistance.

Over 50 general hospitals, variety of sizes, specialties & locations.

FREE: We do all paper work, NO PLACEMENT FEE.

PROFESSIONAL NURSE RECRUITERS (Authorized Rep. of Hospitals) 1316 Wilshire Blvd., Suite 12 Los Angeles, California 90017

Tél.: (213) 481-0666 or 481-0691

Without obligation, please send me more information and an application form.

Name:
Address:
Tel.: ( )
Licenses:
Specialty:
Year Graduated: Prov

sented in such a way as to encourage

further reading.

An addition to the text is a chapter on anxiety and the student nurses' role. It is a short chapter but it may help the student to look for the first time at her own feelings and reactions to such things as injustice, disfigurement, and death.

The patient and his reaction to illness—physically, emotionally, and spiritually—remain the focus throughout the text. The concepts of nursing care are well integrated. Rehabilitation is dealt with only briefly in the last two chapters.

This is an interesting text to read, but it lacks the depth necessary even for a beginning nursing student. It would be an excellent supplement to another nursing text.

Rehabilitative Aspects of Acute and Chronic Nursing Care by Ruth Perin Stryker. 236 pages. Toronto, Saunders, 1972.

Reviewed by Miriam Pill, Former Director, Nursing Service, Maimonides Hospital, Montreal, Quebec.

The author states that the book is designed "to help nurses implement rehabilitative steps in acute and long-term care, regardless of physical setting," and confines her material to physical rehabilitation while acknowledging the importance of psychosocial rehabilitation.

The book is divided into four parts. In the first, Ms. Stryker speaks of the history of rehabilitation and the evolution of present techniques; she states the current and future need for more emphasis on rehabilitation in the total nursing curriculum.

The second part is devoted to the nursing care required and emphasizes the role of the nurse as a teacher. The author comments on most of the specific problems encountered in rehabilitative

Part three concerns specific nursing skills required, and in part four the author writes of the adjustments that can be made to aid the patient in returning to the community, leading a normal life within the disabled person's limitations.

The definition of rehabilitation is clear and realistic with broad emphasis upon the role of the nurse and the family, while the focus is on the patient throughout the book. However, the role of motivation could be more clearly

The emphasis is on rehabilitation in an acute setting rather than a chronic long-term care setting, but it is an excellent reference book for nurses and a good addition to any nurse's library.

### **AV** aids



These parents and teachers in London, Ontario, are being filmed for the motion picture study *Better Than It Was Before*, which shows the involvement of London public and high school students, teachers, nurses, and parents in the London board of education's family living program.

FILMS

A film entitled Better Than It Was Before (16 mm, black and white, 28 mins. 30 secs., 1972) was produced for the Metropolitan Life Insurance Company, in cooperation with the London School Board and London medical community, for the 1972 National Conference on School Health (News, December, p. 17). This motion picture study of the London schools' health education program was originally made on half-inch tape.

The film, of particular interest to school educators, nurses, and school boards, shows teachers, students (from the early grades of public school throughout high school), and parents involved in various aspects of the family living curriculum. Although only a part of this innovative program could be covered in the film, a number of topics are mentioned: personal safety, communicable diseases, drugs, family planning, and reproduction.

At the time the film was shown at the

end of October, Metropolitan Life had only the one print. However, a company representative told *The Canadian Nurse* in November 1972 that another three to ten prints of the film would be ordered. Anyone who would like to borrow a print to review the film can write to: Health and Welfare Division, Metropolitan Life Insurance Company, 180 Wellington St., Ottawa, Ontario. If a print is not immediately available, the person requesting the print will be put on a waiting list.

Complete information about the

#### Change of Address

In the September 1972 issue, a Calgary address was given for Sound Treks Audio Productions, which announced it was establishing a cassette service. That address has been changed to: Box 12, Site 14, R.R. 4, Calgary, Alberta T2M 4L4.

family living program can be obtained by writing to: London Board of Education, P.O. Box 5873, London 12, Ontario.

**AV PACKAGE** 

☐ The Au-Vid Learning System is a tool to help students in learning medical terminology. Focusing on diagnostic and operative terms related to the cardiovascular system, the 12 programs in this series are designed for self-

instructional purposes.

This learning system is multisensory; each program is presented on cassette tape, coordinated with the use of visual illustrations in a student manual. Based on concepts of programmed instruction, the characteristics of this system include clear and logical presentation of materials, reinforcement, and immediate feedback.

The package is entitled "Diagnostic and Operative Terminology: Cardiovascular." Its programs give the student the precise meaning, pronunciation, and spelling of hundreds of terms related to the cardiovascular system.

Au-Vid packages are offered for evaluation to educators and qualified personnel in the health care field. For details regarding a free preview, contact Mr. Lew Herndon, Au-Vid, Inc., Box 964, Garden Grove, California 92642, U.S.A.

LITERATURE AVAILABLE

Aids for Health Teaching: A Catalog for Schools is available from the Metropolitan Life Insurance Company, health and welfare division, 180 Wellington St., Ottawa KIP 5A3. The 13-page catalog lists special school materials available. These include classroom materials, such as booklets and pamphlets, filmstrips, and 16 mm sound films. Some of the topics covered are safety, drugs, nursing, health research, detection of health problems in children, weight control, medical emergencies, alcoholism, and stress. A request form for ordering these materials comes with the catalog.

Another booklet available from Metropolitan Life is *Publications and Films on Health and Safety*. The five 16 mm sound films listed, which can

be borrowed free of charge with four weeks' advance notice, are available in English and French. Publications are grouped under the headings "family health" and "safety." Topics covered are home nursing, immunization, children's eyesight, children's sleep, exercise, personal health record, teenage driving, and teenage babysitting.

#### accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, except reference items, may be borrowed by CNA members, schools of nursing and other institutions. Reference (R) items (archive books and directories, almanacs and similar basic books) do not go out on loan. Theses (also R) are Reserve and may go out on interlibrary loan only.

Request for loans should be made on the "Request Form for Accession List" and should be adressed to: The Library, Canadian Nurses' Association, 50 The Driveway, Ottawa, Ont. K2P

1E2.

No more than *three* titles should be requested at any one time.

#### BOOKS AND DOCUMENTS

- 1. Busic psychiatry, by Myre Sim. 2ed. Edinburgh, Churchill Livingstone, 1972. 286p.
- 2. Canadian income tax for businessmen and accountants, by W.G. Leonard. 8ed. Don Mills, Ont., C.C.H. Canadian Limited, 1972, 463p.
- 3. The cardiac patient; a comprehensive approach, by Richard G. Sanderson. Toronto, Saunders, 1972. 548p. (Saunders monographs in clinical nursing no.2)
- 4. A career model for nurse practitioners, by Lucile A. Wood. Los Angeles, Allied Health Professions Project, Univ. of California, 1972. 94p.
- 5. Catalogue of educational & technical films for the medical profession, by Medical Film Library of Canada. Montreal, City Films Ltd., 1972, 180p.
- 6. A catalogue of films on the medical sciences available from the National Science Film Library. Ottawa, Canadian Film Institute, 1972. 144p.
- 7. The concise home medical guide. New York, Grosset & Dunlap, 1972. 630p.
- 8. Contraception, by Lionel Gendron. Translated by Jane Brierley. Montreal, Harvest House, 1971. 154p.
- 9. Convention & meetings facilities and services in Canada, 1972-73. Willowdale,

- Ont., Effective Communications Ltd., 1972. 104p.
- 10. Critical issues in continuing education in nursing. Report of a National Conference on Continuing Education in Nursing, 3rd., University of Wisconsin, Oct. 19-21, 1971. Madison, Wisc., Dept. of Nursing, Health Science Unit, University of Wisconsin—Extension, 1972. 147p.
- 11. Drugs and pharmacology for nurses, by Sidney John Hopkins. 5ed. Edinburgh, Livingstone, 1971. 350p,
- 12. Experimentation with human subjects. Edited by Paul A. Freund. New York, Braziller, 1970, 470p.
- 13. The future of work and leisure, by Stanley Parker. London, MacGibbon and Kee, 1971. 160p.
- 14. A handbook of venereal diseases, by William M. Platts. Christchurch, N.Z., Peryer, 1972, 94p.
- 15. The health aide, by Jane Henry Stolten. Boston, Little Brown, 1972. 373p.
- 16. High-risk newborn infants; the basis for intensive nursing care, by Sheldon B. Korones et al. St. Louis, Mosby, 1972, 245p. 17. Independent living for older people; a report of a Conference on Gerontology, 21st, University of Florida, Feb. 6-8, 1972. Edited by Carter C. Osterbind, Gainesville, Fla., University of Florida Press, 1972, 142p. (Institute of Gerontology series no. 21)
- 18. L'infirmière anesthésiste, par Joan K. Hobkirk. Traduit de l'anglais. Paris, Maloine, 1972. 188p.
- 19. Information retrieval: notes for students, by John R. Sharp. New York, Seminar Press, 1970. 90p.
- 20. Initiation à la recherche dans les sciences humaines, par Marc-Adélard Tremblay. Montréal, McGraw-Hill, 1968. 425p.
- 21. Ketalar; Ketamine hydrochloride. Montreal, Parke-Davis, Research Division, 1971. 189p.
- 22. Learning experience guides for nursing students, by Anne K. Roe and Mary C. Sherwood. New York, Wiley, 1970-71. vol. 2 and vol. 3
- 23. Nursing administration in the hospital health care system, by Edythe Alexander. St. Louis, Mosby, 1972. 317p.
- 24. Nursing skills for allied health services. Edited by Lucile A. Wood. Toronto, Saunders, 1972. 2 vols.
- 25. Organizing knowledge in libraries; an introduction to information retrieval, by C.D. Needham. 2d rev. ed. New York, Seminar Press, 1971. 448p.
- 26. Paramedical pathology; fundamentals of pathology for the allied medical occupations, by Alvin F. Gardner. Springfield, 111., Thomas, 1972, 200p.
- 27. Parents and children in the hospital; the family's role in pediatrics, by Carol B. Hardgrove. Boston, Little, Brown. 1972, 276p.
- 28. Proceedings of International Conference on Nosocomial Infections, Center for Disease Control, 1970. Chicago, American Hospital Association, 1971. 334p.
- 29. The professional ethic and the hospital service, by Norah Mackenzie. London,

- English Universities Press. 1971. 70p.
- 30. A programmed course in cataloguing and classification, by Albert Frederick Johnson. London, Deutsch, 1968, 132p.
- 31. Report of the Conference on Prostaglandins in Fertility Control, Third, Karolinska Institutet, Stockholm, Sweden, Jan. 17-20, 1972. Stockholm, Sweden. World Health Organization, Research, and Training Centre on Human Reproduction, Karolinska Institutet, 1972. 258p.
- 32. Retirement. Edited by Frances M. Carp. New York, Behavioral Publications, 1972. 409p. (Gerontology series)
- 33. Saunders review for practical nurses, by Claire Brackman Keane. 2ed. Toronto, Saunders, 1972, 453p.
- 34. Special libraries, by Manil Silva. Plymouth, Deutsch, 1970. 96p.
- 35. Structure and function of the body, by Catherine Parker Anthony, 4ed, St. Louis, Mosby, 1972. 175p.
- 36. Vademecum de l'éducation et du travail, par Jacques Trahan, Rollande Gagné et Jean-Claude Deschenes. Montréal, Editions Intermonde, 1972. 1 vol.

#### PAMPHLETS

- 37. L'équipe de la santé; un modèle conceptuel par Madelon George et al. Traduction d'un texte publié dans "The Journal of Nursing Administration." Montreal, Association des Infirmières et Infirmiers de la Province de Québec, 1972. 8p.
- 38. Fellowships and scholarships offered by private donors and foreign governments for Canadian students, administered by AUCC. Ottawa, Association of Universities and Colleges of Canada, 1971. 21p.
- 39. Nursing careers recruitment: a multiimpact approach. Cleveland, Ohio, Cleveland Area League for Nursing, 1972, 44p.
- 40. Public Affairs Committee. Pamphlets. New York. 1972.
- no.479 Helping the child who cannot hear, by Samuel Moffat. 28p.
- 41.—.no.480 The rights of teenagers as patients, by Theodore Irwin. 28p.
- 42.—.no.481 Public service employment: jobs for all, by Robert Leckachman. 28p.
- 43. .no.482 *Pregnancy and you*, by Aline B. Auerbach and Helene S. Arnstein. 28p.
- 44. .no.483 Watch your blood pressure! by Theodore Irwin. 28p.
- 45. Settlement and agreement costing: some technical aspects and some suggested ultimate objectives, by Felix Quinet. A paper to the Research Committee of the Employers' Council of British Columbia, Vancouver, May 31, 1972. Ottawa, 1972. 15p.
- 46. Survey of human reproduction—research and training in Canada, conducted by International Development Research Centre in collaboration with the Health Systems Research Unit, University of Toronto. Ottawa, 1972, 11p.
- 47. Training of medical assistants and similar personnel; seventeenth report of the Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel. Geneva, World Health Or-

#### accession list

ganization, 1968. 26p. (Its Technical report series no. 385)

GOVERNMENT DOCUMENTS

Canada

- 48. Dept. of National Health and Welfare. Special Advisory Committee to Advise the Food and Drug Directorate on All Aspects of the Safety and Efficacy of Oral Contraceptives Marketed in Canada. *Report.* Ottawa, Information Canada, 1970. 44p. (RX Bulletin vol. 1, no. 10, Dec. 1970)
- 49. Statistics Canada. Census of Canada, 1971. Advance bulletins. Ottawa.
- 50.— Census metropolitan areas; revision of the concept, criteria and delineations for the 1971 census, by F. Rícour-Singh. Ottawa, 1972. 20p.
- 51.— Surgical procedures and treatments. A report on surgical operations and non-surgical procedures performed on inpatients in Canadian hospitals by length of stay, 1968, Ottawa, 1972, 78p.

United States

52. Division of Nursing. Planning for nursing needs and resources. Prepared by... Helen V. Foerst and Florence E. Gareau, principal authors and Eugene Levine, contributing author. Bethesda, Md. (For sale by Supt. of Docs., U.S. Govt. Print. Off.,

Washington, 1972) 204p. (U.S. DHEW Publication no. (N1H) 72-87)

- 53. National Center for Health Services Research and Development. Guidelines for health services R & D: shared services, by Sam A. Edwards. Chicago, 111., 1972. 43p. (U.S. DHEW Publication no. (HSM) 72-3023)
- 54. National Institutes of Health. Accreditation and certification in relation to allied health manpower by Maryland Y. Pennell et al. Bethesda, Md.; for sale by U.S. Govt. Print. Off., Washington, 1971, 43p. (U.S. DHEW Publication no. (NIH) 71-192)

STUDIES DEPOSITED IN CNA RESPOSITORY COLLECTION

- 55. A comparative study of training programs for male nursing assistants and orderlies in Saskatchewan, by Lynn M. McCaslin, Washington, D.C., 1966, 91p.R
- 56. Coronary care nursing program; a report of a demonstration Jan. 1, 1971 to Sep. 30, 1972, by Patricia C. Styran. Toronto, Continuing Education Program for Nurses, University of Toronto, Faculty of Nursing, 1972, 40p, R
- 57. Effets d'un programme de resocialisation introduit par l'infirmière chez les personnes âgées en foyer en vue de réduire le processus de désengagement, par Diane Goyette. Montreal, 1971. 81p. (Thèse (M. Nurs.) Montreal) R
- 58. An exploratory study of the problem of mobility among graduate nurses who

terminated their employment from a community health association, by James J. Broderick. Ottawa, 1971. 98p. (Thesis (M.H.A.) — Ottawa) R

59. History of Regina General Hospital, School of Nursing. Regina, 1972. 7p. R

- 60. Job satisfaction and environmental climates: a study of registered staff nurses in a public Catholic and federal hospital in Ontario, by Hugh Charles Graham. Ottawa, 1971. 164p. (Thesis (M.H.A.) Ottawa)R
- 61. Needs of non-institutionalized cancer patients, their utilization of, costs of, and the availability of services for them, in three areas in Ontario. Report 1: Patient—physician—community survey, by Terry E. Lindsay and Margaret C. Cahoon. Toronto, Ontario Division, Canadian Cancer Society 1972. 357p. R
- 62, Nursing research in Alberta: a beginning descriptive study, by Ada Elizabeth Simms. Edmonton, 1972, 117p. (Thesis (M.H.S.A.) Alberta) R
- 63, Perceptual style and the adaptation of the aged to the hospital environment, by Marilyn Margaret Steels, Cleveland, Ohio, 1972, 127p. (Thesis (M.S. Nurs.)—Case Western Reserve) R
- 64. A study of the opinions of directors of the personnel and nursing departments of large general hospitals regarding the centralization of the nursing personnel functions in the personnel department, by William R. Dubuc. Ottawa, 1971. 92p. (Thesis (M.H.A.) Ottawa) R

Request Form for "Accession	List"
-----------------------------	-------

#### CANADIAN NURSES' ASSOCIATION LIBRARY

Send this coupon or facsimile to: LIBRARIAN, Canadian Nurses' Association, 50 The Driveway, Ottawa, Onfario. K2P 1E2. Please lend me the following publications, listed in the ................................. issue of The Canadian Nurse, or add my name to the waiting list to receive them when available: Item Author Short title (for identification) No. ...... ...... Requests for loans will be filled in order of receipt. Reference and restricted material must be used in the CNA library. Borrower ...... Registration No. ...... Position .....

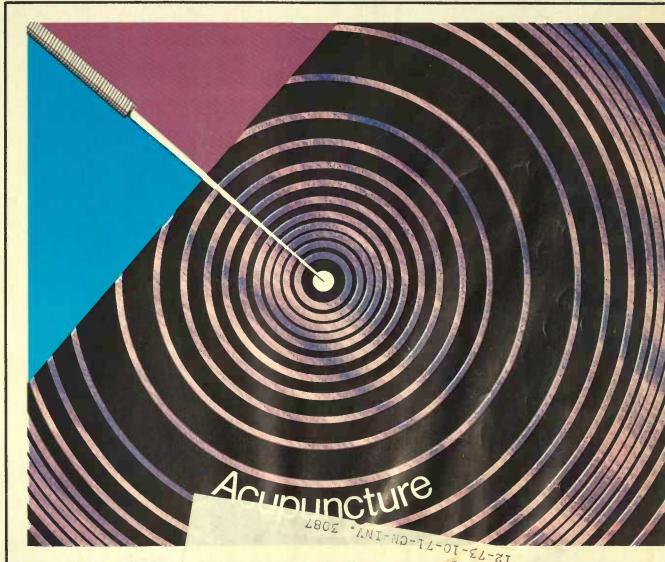
# The Canadian

February 1973

Nurse

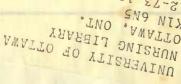
DO NOT TAKE

13 FEV 1973



trace elements in food

health care at an international airport





# BE PART OF TH

#40852 — The New Smock Look with dainty lace. Pant dress. Action lack. Gold only as complete set.

ROYALE CORDED' knit, corded stitch olyester-blended with nylon Soft Blue, All White \$24.00

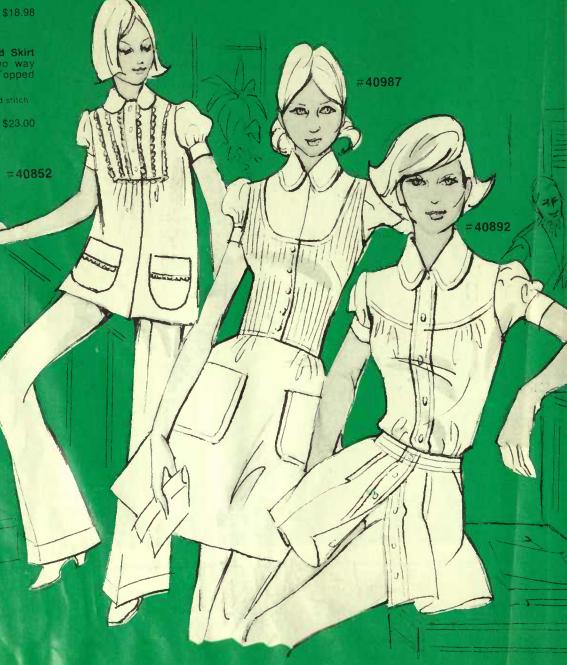
#40987 — Jumper Effect combined with puffed sleeves. Gently shirred kirt, back zipper, action back.

'ROYALE SUPREME''
combined with permanently tucked kn.t White only

Sizes 3-13, Junior

#40892 — The Body Suit and Skirt Set, snap closure bottom. Two way stretch fabric for perfect fit. Topped with pleated front snap skirt.

'ROYALE CORDED' knit, corded stitch polyester blended with nylon





CAREER APPAREL

AVAILABLE AT FINE STORES ACROSS CANADA

WHITE SISTER UNIFORM INC.

# ASHION SCENE



Sizes 3-13



AVAILABLE AT FINE STORES ACROSS CANADA



### The Canadian Nurse



A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 69, Number 2

February 1973

Coronary Patients and Their Families Health Care at Toronto International Airport ...... D.S. Starr 

The views expressed in the editorial and various articles are those of the authors and do not necessarily represent the policies or views of the Canadian Nurses' Association.

New Products Letters Research Abstracts 7 News 50 Books 45 Dates 56 Accession List 46 In a Capsule Index to Advertisers

Executive Director: Helen K. Mussallem • Editor: Virginia A. Lindabury • Assistant Editors: Liv-Ellen Lockeberg, Dorothy S. Starr • Editorial Assistant: Carol A. Dworkin • Production Assistant: Elizabeth A. Stanton • Circulation Manager: Beryl Darling • Advertising Manager: Georgina Clarke
• Subscription Rates: Canada: one year,
\$6.00; two years, \$11.00. Foreign: one year,
\$6.50; two years, \$12.00. Single copies: .75
cents each. Make cheques or money orders payable to the Canadian Nurses' Association.

• Change of Address: Six weeks' notice; the old address as well as the new are necessary, together with registration number in a pro-vincial nurses' association, where applicable. Not responsible for journals lost in mail due to errors in address.

Names

47

Manuscript Information: "The Canadian Nurse" welcomes unsolicited articles. All manuscripts should be typed, double-spaced, on one side of unruled paper leaving wide margins. Manuscripts are accepted for review for exclusive publication. The editor reserves the right to make the usual editorial changes. Photographs (glossy prints) and graphs and diagrams (drawn in india ink on white paper) are welcomed with such articles. The editor is not committed to publish all articles sent, nor to indicate definite dates of publication.

Postage paid in cash at third class rate MONTREAL, P.Q. Permit No. 10,001. 50 The Driveway, Ottawa, Ontario. K2P 1E2 Canadian Nurses' Association 1973

In her book on the history of the International Council of Nurses, Daisy Caroline Bridges commented on the death of Adelaide Nutting, the famous Canadian-born nurse who became the first professor of nursing in the world: "With the death of Miss Nutting there seemed to pass an epoch in international, as well as American, nursing.

The same words are true of Daisy Bridges. With her death (Names, page 47), an epoch in international, as well as British, nursing has passed. Indeed, the world of nursing has lost a friend and a great leader, as her work, devotion, and vision encompassed every country.

Like most outstanding persons, Daisy Bridges had a delightful sense of humor. Almost everyone who knew her can recall something amusing she either did or said. My favorite concerns the Canadian nurse who had the misfortune to fall down some steps while attending a nurses' meeting. She was admitted to hospital for observation, and while there had skull x-rays taken. She was visited by her friend Daisy, who said soothingly: "Don't worry, my dear. I've seen the x-ray report on your head, and there's nothing in it!"

Before the last ICN Congress in 1969, we asked Daisy Bridges to write an article about the ICN. In this article appears one of her beliefs about its importance. After listing ICN objectives, she states:

'There is another objective which, although not included in the formal constitution, is equally important the promotion of friendship and fellowship among the nurses of the world. Throughout more than half a century, this spirit of international cooperation has been built up. It is a priceless heritage to be cherished and handed on to succeeding generations, and it is our contribution, as nurses, to the cause of world peace.'

At the end of this article, she quoted from an old Sanscrit proverb: "Walk together, talk together all ye peoples of the earth; then

and only then, will ye have peace."
When Daisy Bridges retired as general secretary of the ICN in 1961, many tributes to her were published in the International Nursing Review. One read, in part, "Her services to the ICN and to nursing the world over are incalculable. Yet she remains an essentially simple person to whom duty, loyalty, integrity, and caring deeply about other people and their problems are allimportant. She must surely be one of the great nurses of our time."

\_\_ V.A.L. And indeed she was.

THE CANADIAN NURSE 3

### letters

Letters to the editor are welcome. Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Thanks author

Thanks to Barbara Pilkey for the article "Retraining Daze" (December (December 1972).

I can imagine how she felt after 23 years' absence from nursing. I faced a small dilemma after only one and a half year's absence. This really slowed me down. For example, I had to stop to figure out the old drug problems I used to do in my head. Not only the names of drugs changed, but the familiar ones were produced with different mgm and ec per vial. It slowed me down enough to check and recheck everything I did. Is there anything wrong with that?

l also have had experience with other nurses who have been away much longer than myself. But in my opinion they are safe nurses, given an adjustment period, because they do check with a little

more care.

Another point: these returning nurses seem to have a greater capacity for empathy, especially if their absence was due to illness or childbearing and childrearing. They bring with them not only their maturity, but also their experiences. I think being on the receiving end of care can really point out areas for improvement.

More nurses should come out of retirement and accept the challenge of working again. After the initial step, the fear will slowly melt away. The names of pills and drugs might change, but even time cannot change the nature of illness and, most important of all, the patients do not change.

Returning nurses have all the time, help, and admiration I can give them, because it does take courage. — R.N.,

Halifax, Nova Scotia.

Book review does injustice

A review of Jeannette E. Watson's Medical-Surgical Nursing and Related Physiology appeared in the December issue (page 50). The comments by the reviewer relate to the first paragraph of the preface; in regard to this, she interjects her own ideas. As the actual content of the book is not discussed, a considerable injustice is done the author.

The physiology in each chapter is selective and precise. The nursing care of patients with medical-surgical disorders is dealt with in detail. References listed at the end of each chapter are

up-to-date and relevant to the content.

The book is well written. Clear writing should not be confused with simplicity of content. No one text can be definitive as far as range of content is concerned. Supplementary readings in current journals in both nursing and medicine are essential to keep abreast of the rapid changes in health.

I would have no reservation in recommending Ms. Watson's text to diploma students, nor to beginning students in a baccalaureate program. Several of my colleagues have read the text and concur with my opinion. -Irene Leckie, Professor, University of

New Brunswick, Fredericton.

Jacquelyn Peitchinis reviewed Medical-Surgical Nursing and Related Physiology by Jeannette E. Watson in the December 1972 issue, I recognize that the opinions expressed in the review are those of the reviewer. But there are readers who depend, to some extent at least, on opinions expressed in reviews to overcome the problem of keeping up-to-date with current books and literature of all kinds. For this reason, I must contact my nursing colleagues about this particular book review.

As a nursing student, I am using this text, not as a course requirement, but because of its value to me. I do not know of any current book more useful to nursing students of all levels. This is not a text for nursing aides and orderlies, as Ms. Peitchinis would have us think. It is a comprehensive, succinct, and readable text offering a wealth of information in a most accessible form.

Ms. Peitchinis gets completely off the track in mentioning the problems of delineating specific functions of the various categories of nursing service staff. Genuine though they may be, it is not the function of a textbook on medical-surgical nursing to deal with them. Those are the problems of the profession generally and of nursing administrators in particular — of whom Ms. Peitchinis is one. In other words, those are her problems, and she cannot expect the author of a medical-surgical textbook to include them.

As a person with appreciable experience in nursing, I cannot agree with the reviewer that this text is "... too limited a reference source" for graduate nurses — regardless of the route by which they were educated. Grand and glorious will be the day in nursing history when all Canadian nurses can truthfully say they know and are applying the knowledge in this text. — Gloria Kay, B.Sc.N., B.A., Willowdale, Ont.

The December 1972 issue of The Canadian Nurse carries a review of the textbook Medical-Surgical Nursing and Related Physiology by Jeannette Wat-

The reviewer appears to concentrate her remarks on the preface of this book. Although she stresses the levels of preparation, she does not really comment on the content. This textbook is detailed and factual. At the completion of each chapter there is a listing of additional references for the reader who wishes to pursue further information.

There are many predictions that more nursing care will be given in the community. This text could well be a basic reference for staff nurses of community health agencies. — Ethel Irwin,

Toronto, Ontario.

Objects to photo

I would like to voice a small objection to the picture used on page 47 of the December issue of *The Canadian Nurse*.

The picture illustrates the meaning well. My question is: could not a similar illustration have been found with a little less obvious United States identification? After all, this is a Canadian journal and we are more often pleased with it than not.

The "U.S. Mail" on the box caught my eye the moment I opened that page. I wonder how many other nurses reacted as I did. — Virginia Rivard, Director of Nursing, Queen Mary Veterans Hospital, Montreal, Quebec.



skills and experience. Volunteer

St. John Ambulance home nursing and child care courses.

Contact your Provincial Headquarters St. John Ambulance.

### FILM LOOPS AND FILM STRIPS FOR NURSING EDUCATION

Looking for visual teaching materials? Lippincott offers you professionally prepared time savers for self-study or classroom teaching in nursing skills and techniques. Here are three economical, efficient methods:

#### **FILM LOOPS**

Lippincott loops, short silent motion pictures using Super 8 mm. color film permanently loaded on a continuous reel or "loop", are available in series covering: Fundamentals of Nursing Procedures in Patient Care Medical-Surgical Nursing

#### **FILM STRIPS**

Decision Media's 35 mm. film strips accompanied by audio cassettes cover four

critical areas of nursing: Cardiac Care; Respiratory Care; Neurological Care; Post-Surgical Care. These films are compatible with most projection equipment.

### LIPPINCOTT LEARNING SYSTEM

A complete, self-instruction course in the principles, basic procedures and manual skills fundamental to patient care. In preparation, this multimedia program includes student-response filmstrips, color /sound motion pictures, student guides and workbooks, and a comprehensive instructor's guide. In eleven units: Management of the Environment; Posture and Body Mechanics; Making a Bed; Vital Signs; Care of the Mouth; Care of the Skin; Administration of Therapeutic Agents; Oral Medication; Parenteral Medication; Range of Motion; Bowel Elimination.

Lippincott

Serving the health professions in Canada since 1897
J. B. Lippincott Co. of Canada Ltd. 75 Horner Ave.
Toronto 18, Ontario

Representing in Canada: Little, Brown and Company Blackwell Scientific Publications Ltd. Springer Publishing Company, Inc. Write or return this coupon for more information.

- ☐ Please send more information
- ☐ Please send your catalog
- ☐ Please call me

Name

Address

.... City .....

Province .

Phone No

CN 2-73

URIN-TEK makes handling 3,300 gallons of urine specimens a year less onerous, odourous, time-consuming, space-taking and costly.

### Give us just 12 minutes and we'll show you how!



You'll see why major Canadian hospitals have switched to the URIN-TEK System for specimen collection, transportation, testing and analysis.

Our 12-minute audio/visual presentation shows how the URIN-TEK System is actually used in a hospital and why it offers so many attractive advantages, including easy assimilation into your normal routine with a minimum of staff instruction.

If you have seen the URIN-TEK System before and are not presently using it, this presentation will bring you up-to-date on the improvements we've made to make it even more practical.

Once you've seen our presentation, you may like to evaluate the URIN-TEK system in your hospital. We make that easy by offering a oneward trial at *no cost*, no obligation.

To arrange a showing contact your AMES representative or write Grahame Richards at this address.



#### news

**CNA Executive Approves Responses To School Health Recommendations** 

Ottawa — The CNA executive committee, at its meeting in December 1972, approved responses to the recommentions made at the close of a national conference on school health, held in Ottawa in October 1972. (News, December 1972, page 17.)

An ad hoc committee of public health nurses prepared the position paper that was approved by the CNA executive. Chairman of the ad hoc committee was Constance Swinton; committee members were Margaret C. Cahoon, Justine M. Delmotte, Rachel Lamothe, and Marie A. Loyer.

Among other recommendations, the

position paper urged that:

• Those concerned with the development of school health programs permit parents to assume responsibility for the care of their children.

• School health services continue to be an extension of the community services available during the prenatal and postnatal period, the preschool years, and throughout life.

• In the development of school health curricula, appropriate learning experiences be provided to enable students to understand and use available community health resources.

A CNA staff submission contained suggested changes in the school health conference recommendations. Included

in the changes are:

• The school health program should be the joint responsibility of provincial departments of health and education, since health service is involved.

• Provincial departments of education should develop credit courses in health and family life sciences at the secondary level, encompassing physical, mental, and social health education.

Both the position paper and the CNA staff submission were sent to the steering committee for the national conference

on school health.

#### Shortage Of Nurses Exists In Some Provinces

Ottawa — After surveying the provincial nurses' associations about reported shortages in hospital nursing staffs, The Canadian Nurse has learned there have been shortages — in addition to those that generally occur during the summer — in Nova Scotia, northern

New Brunswick, parts of Quebec, and Saskatchewan.

Dorothy Miller, public relations officer for the Registered Nurses' Association of Nova Scotia, told *The Canadian Nurse* that shortages are worse in the summer, but the situation is bad all year round. This is because of hospital budget restrictions or poor administration of budgets, she explained

According to Ms. Miller, "The RNANS is very concerned about the situation throughout the province and has submitted 'A Statement of Concern' to the minister of public health and the health council." This statement mentions the association's position paper on the practice of professional nursing in Nova Scotia. The RNANS expressed concern about obstacles to practicing professional nursing, such as nonnursing tasks and inadequate numbers of staff.

Ms. Miller said the statement of concern, submitted September 30, 1972, gives definite examples of situations in hospitals because of shortages. The statement, she said, "concludes by appealing to the minister of public health and the health council, on behalf of the 5,063 nurses in N.S., to use all possible means in providing adequate numbers of qualified nursing personnel and supporting services for the nursing departments of our hospitals."

In New Brunswick, Nancy Rideout, liaison officer with the New Brunswick Association of Registered Nurses, said shortages exist mainly in the northern, more isolated part of the province. However, she explained that the situation in the larger cities is continually changing; hospitals sometimes have

problems finding nurses.

At a meeting of directors of nursing in New Brunswick October 24 to 25, 1972, reference was made to press stories that closure of hospital units during the summer was due to nurses being on vacation or students being withdrawn from specific hospitals. The directors discussed other reasons, such as doctors' vacations and patients' unwillingness to enter hospital during the vacation period.

Gertrude Jacobs, Association of Nurses of the Province of Quebec, noted that some hospitals claim to have a shortage of nurses, but pointed out some nurses in the province are not working. The large English-speaking hospitals in Montreal are asking for nurses, she said. As well, there is a shortage in outlying districts.

Although there have been newspaper accounts of a large decrease in the numbers of foreign nurses going to work in Quebec, Ms. Jacobs stressed that the ANPQ has been receiving many requests about nursing in the province.

Ms. Jacobs explained that the three English-language CEGEPs in Quebec have admitted fewer nursing students than did the hospital schools, which have been phased out. However, she said these CEGEPs plan to admit more students. French-language CEGEPs, on the other hand, have been admitting larger numbers of nursing students.

Doris Gibney, Registered Nurses' Association of Ontario, told *The Canadian Nurse* early in January 1973 there is not a shortage of nurses in the province, but there is a problem of getting enough nurses to work in the northern

areas.

Commenting on the situation in Saskatchewan, Betty Schill, public relations officer for the Saskatchewan Registered Nurses' Association, said a shortage of nurses in the rural areas was routine. But she also mentioned shortages in Regina, Saskatoon, and Yorkton.

The Regina Grey Nuns' Hospital had a nursing shortage of three or four full-time RNs throughout the summer of 1972, but did not have to curtail

any ward services.

At the Regina hospital there were 19 resignations of general duty nurses in June 1972, compared with nine in June 1971, and 21 resignations in August 1972. According to the hospital's director of nursing, part of the reason for the increased shortage in 1972 might have been because there are only three schools of nursing left in the province.

At University Hospital in Saskatoon, there was a shortage of operating room nurses in the summer of 1972, although

no services had to be cut.

Throughout the summer of 1972, Yorkton Union Hospital was short of relief nurses, as regular relief nurses were used to replace full-time nurses, and the hospital had to cut back on some surgery. At the end of 1972, there were still three full-time nursing positions open.

#### news

The director of nursing at Yorkton Union Hospital gave a number of reasons for the shortage: new graduates want to work in larger centers; a year ago, the hospital's school of nursing was closed; and because nurses are no longer getting married as soon after school as they used to, they are now more mobile.

In Alberta and Manitoba, a distribution problem, rather than an actual shortage of nurses, was mentioned. There has been difficulty in getting enough nurses to work in the northern,

isolated areas.

The Registered Nurses' Association of British Columbia said in September 1972 it would investigate a reported shortage of RNs during the past summer. "We hope to get this study underway soon and to be able to come up with useful data prior to next summer," RNABC president Margaret Neylan said.

RNABC said the study would include the many factors involved in staffing patterns, such as recruitment, educational opportunities, individual factors, and working conditions. The study also called for making enquiries in other provinces to find out if a similar problem exists, and if so, what steps have been taken to alleviate hospital staffing problems in summer months.

The only province that reported a surplus of nurses was Prince Edward Island. Laurie Fraser, executive secretary registrar of the Association of Nurses of Prince Edward Island, said: "Our school of nursing... still has a three-year program where the third-year students are considered additions to hospital nursing staff. When the students were on vacation [ in 1972], there were always enough nurses in the community to do part-time work...."

Ms. Fraser added that in late August and early September 1972, there were few positions for the new nursing graduates, many of whom were forced to seek employment in other provinces.

ANPQ Recommendations Included In Quebec Hospital Regulations

Quebec City, Quebec—Some of the changes recommended by the Association of Nurses of the Province of Quebec (ANPQ) are embodied in the regulations for Bill 65, the Act on health and social services in Quebec, which came into effect January 1, 1973.

The position of director of nursing service may no longer exist in Quebec

West Indian Nurses Enjoy Canadian Nursing Books



Nurses at the Victoria Hospital in Castries, Saint Lucia, the West Indies, were pleased to receive three boxes of nursing books from the Canadian Nurses' Association, sent through the Overseas Book Centre of Canada. Pictured with some of the books are student nurses, staff nurses, nursing assistants, the sister tutor (chief nursing instructor) of the Victoria Hospital school of nursing, Pamela Baptiste, second from left, and the assistant tutor, Andrita Louis, fifth from left. The books are basic nursing texts removed from the shelves of the CNA library when new editions were purchased; the nursing content of the gift books is still valid. The Overseas Book Centre is a nongovernmental organization funded 40 percent by the Canadian International Developmental Agency; the remaining support comes from individual donations.

hospitals; the new position title is "head of the nursing department" in Quebec hospital centers for short-term or pro-

longed care.

The requirement for a nursing department is a change in the final form of the regulations to Bill 65. (Some parts of Bill 65 were discussed in Lisette Arcand's article, *New health programs in Quebec*, December 1972, pages 27-30.) The draft regulations made a nusing department optional, and the head of the nursing department was to be responsible to a director of hospital services who reported to the general manager.

The final regulations state that the head of the nursing department is responsible, under the authority of the general manager of the hospital, for the coordination and evaluation of nursing care in the hospital center.

The government's proposals for the regulations were discussed at a meeting of the ANPQ in August 1972. (News, October 1972, page 8.)

Another change in the regulations that reflects recommendations from ANPO members at the August meeting

is the restriction of telephone orders to an intern, resident, or nurse on duty in the hospital; telephone orders must be countersigned by the physician or dentist within 72 hours.

The ANPQ recommendation that a grievance procedure for physicians and dentists should include nurses who are not covered by a collective bargaining agreement is not in the regulations.

Fitness And Health Conference Aims At Fitness For All Canadians

Ottawa — Keith McKerracher, in addressing the national conference on fitness and health December 6, envisioned 3.5 million Canadians on regular exercise by 1976. As director general, Sport Participation Canada, he would like to get Canadians away from their TV and grandstand interest in sports and on to the playing fields.

It could be "fear of dying, the fun that a physically active life offers, the fun of playing with others... that would

get them there," he said.

(Continued on page 10)



DEMONSTRATION AND FOLDERS UPON REQUEST

#### news

(Continued from page 8)

His year-old program is trained on the personal fitness of Canadians. It involves education of citizens regarding their health problems; motivation; solution, offering individual or group recreation, individual or group exercise, or competitive sports; and reminder advertising through the media.

Earlier in the day, the United States government program of expenditure on fitness was outlined by Casey Conrad, the executive director of the President's council on physical fitness and sports; and the Swedish program by Berit Brattnas, attaché to the Royal Consulate General of Sweden in New York.

The Swedish fitness program has as its purpose the involvement of everyone in the land at his or her level of capability or fitness, with competitions suited to the ability of the performer. According to Ms. Brattnas, the government considers fitness an important investment in society, having recognized as a poor use of funds the education of a doctor who graduates at 25 and dies of a heart attack at 40 years of age.

Sweden, a country of 8,000,000 people, has 13,500 sports clubs with a total of 2,000,000 members. Sports, promoted through the media, schools, and commercial firms, are being developed "from a hobby for a few into a need for the many, and physical fitness programs for senior citizens have 500,000 participants," Ms. Brattnas said. Her talk ended. "No matter what or who we are, we should never neglect exercise to keep our body as beautiful as nature intended it to be."

From the 17 workshops of the conference came recommendations that called for a marketing campaign to sell the idea of physical fitness; government provision of a delivery system of preventive and fitness service centers across Canada; physical education programs, beginning in elementary school; and availability of recreation for all Canadians, including the aged and disabled.

B.C. Nurses Discuss Report
On Community Health Centers

Vancouver, B.C.—The Registered Nurses' Association of British Columbia expressed general agreement with the community health care concept of the Hastings Report at a forum sponsored by the University of British Columbia's Health Sciences Centre October '72.

About 800 health professionals attended the all-day session to discuss the report with Dr. John Hastings, chairman of the Community Health Centre Project Committee, and committee members Patricia Fulton and Dr. Anne Chrichton.

Speaking for the RNABC, Helen L. Shore, assistant professor at the University of British Columbia school of nursing, generally agreed with the community health center concept, but questioned the foeus on the provision of basic medical services rather than on basic health services.

"We feel that the services coming from the center and the influence that the center exerts on the community must promote the well-being of the citizens much more vigorously if we hope to see some evidence of a relationship between the health status of the community and the health services provided," Ms. Shore said.

On the matter of nurse participation in services provided by community health centers, she noted that although the report refers to the assistant to the physician and the physician surrogate, it "does not pay sufficient attention to the role of the nurse as associate of the physician."

According to the RNABC spokesman, there will be an urgent need for educational programs designed to prepare nurses to function in different ways within a new method of health care delivery. She also said continuing education, available on a regional basis, as well as changes in the basic preparation of nurses were required.

Ms. Shore pointed out the report's implications for change in the distribution of nurses employed, presently 82.5 percent of nurses employed in British Columbia practice in hospitals or other institutions, whereas only 15.2 percent work "at the other end of the health/illness continuum, promoting health and preventing illness."

The public must be educated to assume greater responsibility for health, she concluded. "An educated public with a sense of responsibility for its own health will be the most valuable asset of any health services system."

Work Is A Basic Biologic Need Selye Tells Fitness Conference

Ottawa — Work is a basic biologic need of man. The question is not whether we should or should not work but what kind of work suits us best, said Hans Selye, director of the Institute of Experimental Medicine and Surgery, University of Montreal. He spoke to participants at the national conference on fitness and health Dec. 5, 1972.

"Exercise of body and mind is as

necessary to life as respiration or eating," Dr. Selye said. A close relationship exists between stress and aging. "Stress is the nonspecific response to any kind of activity at any one time; aging is the sum of all the stresses to which the body has been exposed during a lifetime.

"Each period of stress, especially if it results from frustrating, unsuccessful struggles, leaves some irreversible chemical scars (think of them as insoluble precipitates of living matter) which accumulate to constitute signs of tissue aging. But successful activity, no matter how intense, leaves virtually no such sears. On the contrary, it provides you with the exhilarating feeling of youthful strength, even at a very advanced age. Work wears you out mainly through the frustration of failure."

Dr. Selye advised his audience they can live long and happily by working hard at activity they really love and at which they are reasonably successful.

In a panel discussion of attitudes toward fitness, Raymond Desharnais, assistant professor of sports psychology, Laval University, said there is not necessarily a link between a favorable attitude to physical activity and active practice of activity. Participation or nonparticipation depends on the intensity of the attitude; most people have a favorable attitude to fitness.

Dr. Desharnais said most adults are oriented toward passive participation and, even if the attitude is strongly favorable, there is a gradual decrease in activity with aging. A possible explanation is in the values transmitted by social groups.

High school students participate in physical activity as a means of satisfying needs for physical conditioning, beauty of body, or relief from psychological tension. As the individual grows older, the attitude of professionalization develops. Physical activity is used to measure performance and for victory; this results in highly selective participation

"If the main objective is an increased level of active participation by the general population, we should use the media to promote values other than victory in physical activity," Dr. Desharnais said.

Because individuals will drop out of active participation in physical activity unless the behavior change to participation is consistently rewarded, it might be worthwhile to the a proven level of physical fitness to the premium paid for health insurance, suggested Gerald Wilde, professor of psychology at Queen's University.

Dr. Wilde said encouragement of greater active participation in physical

(Continued on page 14)

# Once upon apatient.

Time was you could spend as much time cleaning surgical suction instruments as using them. But that was before Davol made them all disposable. Yankauer, Poole, Frazier, orthopedic, sigmoidoscopic. and all the tubing to connect them. They all come with the features you expect from the expensive metal ones. But priced right. For single patient use. No fuss. No recleaning It's the Davol difference. The better way. All packed sterile in individual see-through, peelback packaging. Ask your Davol dealer salesman for details. Davol Inc. Providence, R.I. 02901. A Subsidi-DAVOL ary of International Paper Co.



# UROGATE\* The total system to meet all your irrigating requirements

Solutions
Administration sets
Drainbox\*\*

Now with the Urogate System you can choose from four handy big-mouth bottles.

You'll like the new 500 ml. and 1,000 ml. sizes. They're just right when you need smaller volumes of pour solutions.

Or, where you need *larger* volumes, the familiar 1,500 ml. and 3,000 ml. Urogate containers are ideal.

Those generous 38-mm. openings are built for business! For example, you can empty the new 1,000 ml. bottle in 10 seconds. Or empty the 500 ml. bottle in just 7 seconds.

(Or, when you choose, pour a slow, carefully regulated stream.)

No mix-up with I.V. bottles on your shelf either: you can recognize the distinctive Urogate shape at a glance. What's more, these bottles accept only Urogate urologic sets. No chance of accidental intravenous infusion.

You'll find a choice of Urogate solutions and sets for all your surgical and urologic irrigating needs. It will be worth your while to learn the details. Why not talk to your Abbott Representative this week.

# **Urogate**



13

#### news

(Continued from page 10)

activity would be more effective on a community scale than on a national

Canadian Nurses With CARE Help Injured In Nicaragua

Ottawa — An earthquake in December destroyed 80 percent of the Nicaraguan capital of Managua and left some 200,000 refugees. Medical personnel, including Canadian nurses, working with CARE in Nicaragua and surrounding Central American countries were mobilized to help care for the injured.

Heather Mason, a registered nurse from New Brunswick (Names, November 1972, page 44), and her associate from the United States left their Medico team stationed in Honduras to work in a hospital in Chinandega, Nicaragua.

The rest of the Medico team, under the direction of Canadian doctor Kenneth Oekenden, stood by at the 200-bed hospital in Choluteea, Honduras, some 100 miles from Managua, awaiting the arrival of injured evacuees. CARE also sent 10 student nurses from the hospital in Choluteca to work in Nicaragua.

Susan Wright, a nurse from Montreal was working for CARE/Medico at an outpost station in the semiwilderness of Nueva Guinea, Nicaragua, 175 miles from Managua. She was moved to the capital to work with Red Cross

units.

Since she began working for CARE in Nicaragua in May 1972, Ms. Wright has handled a number of emergency situations. Once when the local doctor and nurse were away, she evacuated a 15-year-old mother and her newlyborn twins by eargo plane to the wellequipped Retiro Hospital in Manuagua. This hospital, the main one in the capital, was destroyed by the earthquake.

On two previous oceasions, Ms. Wright took patients to the hospital by road and brought back medical and food supplies, hiking the last 20 miles to her outpost station. A CARE/Medico officer described her as a "sweet, fraillooking girl" who turned out to be "as brave as anyone I've ever met."

At the beginning of January 1973, the Canadian government gave CARE Canada a \$25,000 grant it had requested to help carry out urgently needed aid. By January 6, CARE expected to have set up a refugee center in Costa Rica, authorized to spend \$10,000 for

immediate local purchases.

Because of congestion at Managua airport following the earthquake, CARE moved in supplies by truck from neighboring countries and worked closely with the Nicaraguan authorities to organize widespread food distribution. Although Nicaragua is the largest of the Central American countries, its population is just two million and vast sections of the eastern jungle region are undeveloped.

CARE's Canadian team at Solo, Indonesia, needs two registered nurses, one immediately and one in August 1973. In addition, eight nurses will be needed on two-year contracts within the next few months. Enquiries can be made to CARE, 63 Sparks Street,

Ottawa K1P 5A6.

#### Saskatchewan Workshop Asks **How Nurses Rate As Educators**

Regina, Sask. — Health is really low on the totem pole for most people, Otillia Bieber told 50 nurses at a November 1972 workshop in Maple Creek, Saskatchewan. "Priorities are more likely to be a beach cottage, two cars, and a color television," Ms. Bieber said at the workshop sponsored by Region I of the Saskatchewan Registered Nurses' Association.

Ms. Bieber, nursing consultant with the provincial health department and a part-time faculty member at the University of Saskatchewan school of nursing in Saskatoon, was speaking on the workshop topic "Nurses as educators — how do we rate?" She told the nurses: "By virtue of your professional licence, you have the right and duty to provide health information. This is one of your most important functions.

Nurses, who do not accept the responsibility for teaching health, use the excuse they do not have time to teach during their work day, Ms. Bieber said. She asked: "Is time really your enemy? Or ... are [you] too busy carrying out nonnursing functions?"

The nursing consultant described health teaching as being concerned with learning to live in the healthiest way possible. "Nurses must teach patients the meaning of their illness so they can learn how to change and improve their situation. Patients, families, relatives, and friends must be taught to try and help themselves to get well, stay well, and prevent themselves from getting sick again.'

She pointed out three things patients want from nursing, which are related to health teaching: they want to be treated as individuals, want an explanation of their care, and want to participate as a partner in their care.

Some nurses don't want to tell their patients much because they might (Continued on page 17) Famous NURSE MATES

The most comfortable white duty around) Styles come and go, bu classic moc toe goes on forever, weight and extra-comfortable. Ve v Pili-O-Puff cushioned sean tongue, Longitudinal and m tarsal arch support, arch v for day-long freshness easy-care white wast leather. Fif guaranter return lunmarres No. 610 Mec S

New Kork-Lites Featherweight Style New Kork-Lites Feath
An extremely lightweight protessiona
walker, with the new "bottom" look.
Smart, comfortable lace-up heel
oxtord over bomper toe last. Thick
simulated cork sole with 1½"
cork heel (very slip resistant,
and outwears crepe). Styled
in white washable soft
glove upper leather,
tricot-lined, with arch
vents. The very latest
... reflecting trends
in today's fashions.
Fit guaranteed or
return (summarred)

(Specify size undirecturn dispective rise undirecturn for the company of the co

for size exchange

No. 638 Kork-Lite Shoe .

#### All-Weather NURSES' CAll COD

Stay snug in cool weather, dry in the Traditional Navy with Bright Red lin Finest tailoring of 65% Dacron polye 35% combed cotton. Zepel treated. If Nylon Ouralyn lining. Snap fasteners, openings. Matching head scart. Wash warm water, tumble dry and smooth. SN (up to 34 bust). MEDIUM (35-38) or LE (39-42) . specify size on coupon uniform of the specific size on coupon uniform or specific size on coupon uniform or size. "COLOR".

No. 658 Cape . . . . . . 14.95 6-11 13.95 ea., 12 or more 12.95 3 Gold Initials inside collar, add 1.00 per c:

#### Cobbler-Style TUNIC

Pretty and pecky over uniform, pants, skirt or dress...serves many needs. 200 dnr. washable Nylon Taffeta. 29" long, 20" wide. Huge, handy oversized pockets. Choose all snow-white... er aqua or red with black trim.

No. 360 Tunic . . . 4.98 ea., 6 or more 4.50 ea. 2 Gold Initials on pocket, add 50¢ per tunic.



Vinyl or Dacron APRONS

Professional extra-heavy duly translu-cent viryl apron (lett)...deal for messy jobs anywhere! 36" long, 30" wide. No. 1200 (vinyl Apron . . . 2.69 a. 6-11 2.50 ea., 12 or more 2.25 ea. Dacron apron (right) features scoop neck bib that folds under out-of-sight if desired. 3 gened skirt, side pocket, extra wide hem. Skirt 19" long, 24" wide. Color white only. No. 264 Dacron Apron . . . 3 12 or more 3.50 ea. . 3.98 ea.

2 Gold-Stamped Initials on either apron, add 50s per apron.



#### Nurses' POCKET PAL KIT

Handiest for busy nurses. Includes white Deli-Pocket Saver, with 5" Bandage Shear (both sho opposite page), Tri-Color ball-point pen, p handsome little pen light . . all silver finish Change compartment, key chain.

No. 291 Pal Kit . . . . . . . . 4.95 e 3 Initials engraved on shears, add \$0¢ per kit

#### **Endura STOPWATCH**

A fine Swiss instrument for critical timing. Records to 1/10 second (2 full revolutions per minute). Anti-magnetic, guaranleed accurate. Numerals red and black on white face. Top button starts/stops; side button returns to zero. Grey Cycolac molded case, serrated griptight edge. 18" red neck loop.

No. 15-129-1 Stop Watch . . . 19.95 ea. 3 engraved initials on back, add 1.00 per watch.





#### Pull-Out KEY-KEEPE

End fumbling for keys! Pin key-keeper on u form or in bag. Attach keys to bead chain. P out to use key, rewinds automatically. Ne convenient. Silver finish. In plastic gfft ca-No. 155 Keeper . . . . 249 e 

#### Brass DOOR NAMEPLATES

Trim, distinctive and helpful for callers. Your Name engraved and lacquered into smart solid brass 2½" doorplate. Satin gold with polished border, weather-proof finish, black lettering. Brass nails

DONALD HANSCOM THE HOLBRU

No. 701 Deerplate . 1.98 ea Print name desired clearly on separate paper.



Fast-Action Personalized TOURNIQUE Heavy grey rubber strap with Velcro® brand closure, appli and releases instantly. For blood samples, emergencie Plastic gift box. 3 initials on back included FREE.

No. 641 Tourniquet . Duty free . 2.69 e

14 THE CANADIAN NURSE

# Name Pins... and Other Nice Things... from Reeves

Reeves Name Pins most popular among nurses! Supern quality, smartly styled with sharp, clear names deeply engraved.

#### IT'S EASY TO ORDER REEVES NAME PINS FOR YOURSELF OR FRIENDS!

Choose style you want, shown right. Print name (and 2nd line if desired) on dotted lines below. Check other info in boxes on chart, clip this section and attach to coupon

bottom right. Aftach extra sheet for additional pins
NOTE SAVINGS ON 2 IDENTICAL PINS ... more convenient

2nd LINE: \_ DESCRIPTION Engraved 1 Line | Engraved 2 Lines ALL METAL . . . rich, trim and tailored. Lightweight, smooth edges, rounded corners. ☐ 1 Pin 1.9B 169 ☐ 2 Pins 3.25 ☐ Satir 2 Pins 3.85 Silver apply PLASTIC LAMINATE ... slimmer, broader; engraved thru surface to contrasting core color. Beveled border matches lettering. White Black Does not apply □ 1 Pin .95 □ 1 Pin 1.45 559 2 Pins Letters onl Black
Dk. Blue ☐ 1 Pin 2.5 ☐ 2 Pins 3.8 Gold Silve 100 frame smart, will never discolor. Rounde corners and edges. ☐ 1 Pin ☐ 2 Pins 1 Pin .95 2 Pins 1.65 510

\*Please add 25¢ per order for 3 pins or less

QUANTITY DISCOUNTS: 10-24 pins, deduct 10% -----------

#### ------

BANDAGE SCISSORS Personalized, precision-made forged Lister scissors, Guaranteed 2 years.



31/2" MINI SCISSORS

Tiny, handy, slip into uniform pocket or purse. Choose jewelers Gold or gleaming Chrome plate finish on coupon.

41/2" or 51/2" SCISSORS

As above, but larger for bigger jobs. Chrome finish only. Choose No. 3500 (3½"), No. 4500 (4½") or No. 5500 (5½")... 2.75 pa. f Dez er more... \$2.00 ea. Your initials engraved, add 50¢ per scissors.

#### JEWELRY

#### NURSES CHARMS

Finest sculptured Fisher charms, Sterling or Gold Filled (specify under COLOR on coupon). For bracelet or pendant chain. Add to your collection! No. 263 Caduceus; No. 164 Cap; No. 68 Grad. Hat; No. 8. Band. Scissors . . 3.49 ea. 14K PIERCED EARRINGS
Dainty, detailed 14K Gold caduceus, for on or wear. Shown actual size of caduceus, for on or



Dainty, detailed 14K Gold caduceus, for on or off duty wear. Shown actual size. Gift boxed for friends, too. No. 13/297 Earrings . . . . . . 5.95 per pair.

PIN GUARD Sculptured caduceus, chained to your professional letters, each with pinback/safety catch. Or replace either with class pin for safety. Gold finish, gift boxed. Choose RN, LPN





SCRIPTO PILL LIGHTER Famous Scripto Vu-Lighter with crystal-clear fuel chamber containing col ful array of capsules, pilts and tablets. Novel, unique, yourself or for unusual gifts for friends. Guaranteed Scripto. A real conversation piece! No. 300-P Pill Lighter . . . .



Procket SAVERS
Prevent stains and weart
Smooth, pliable pure white viryl, Ideal
low-cost group gifts or favors.
No. 210-E (right), two compartments
with flow cold estimated calductions. with flap, gold stamped caduceus . . . B for 1.50, 25 or mere 20¢ sa.

No. 791 Ooft) Deluxe Saver, 3 compt. change pocket & key chain . . . 6 fer 2.96, 25 or mere 35¢ sa.



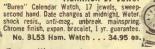
#### NIGHTINGALE LAMP

An authentic, unique favor, gift or engraved award! Ceramic off-white candleholder with genuine gold leaf trim. Recessed cendle cup leandle not included). 7" long.

No. F100S Lamp . . 6.95 ea., 12 or more 4.95 ea. initials end date engraved on gold plaque . . . .



### NURSES WATCHES Hamilton 17 Jewel



Endura Waterproof Swiss made, raised silver full numerals, lumin. markings. Red-tipped sweep second-and, chrome/ stainless case. Includes genuine black reather watch strap. I year guarantee. Very dependable.

BZZZ MEMO-TIMER Time hot packs, heaf lamps, park meters. Remember to check vital signs, give medication, etc. Lightweight, compact (1½" dia.), sets to buzz 5 to 60 min. Key ring. Swiss made. No. M-22 Timer . . . . . 3.98 az. 3 for 9.75 ea., 6 or more 3.00 ea.



#### EXAMINING PENLIGHT

White barrel with caduceus imprint, aluminum bend and clip. 5" long, U.S. made, batteries included (replacement batteries evailable any store). Your own fight, gift boxed. No. 007 Penlight . . . 3.96 ea. Your Initials angraved, add 50¢ per light.

#### **CROSS PEN**

Natalie B. Havens World-famous ballpoint, with sculptured caduceus emblem. Full name FREE engraved on barrel (include name with coupon). Refills avail. everywhere, Lifetime guarantee. No. 6602 12kt. G.F. 11.50 ea No. 3502 Chrome 8.00 ea.

MEDI-CARD SET Handiest reference aver! 6 smooth plastic cards (3½" x 5½") crammed with information, including Equivalencies of Apothecary to Metric to Household Meas, Temp. °C to °F, Prescrip, Abbr., Urinalysis, Body Chem., Blood Chem., Liver Tests, Bone Marrow, Disease Incub, Periods, Adult Wgts., Child's Dosages, etc. All in white vinyl holder with gold stamped caduceus. No. 289 Card Set . . 1.50 ea. 6 or more 1.25 ea. 12 or more 1.10 ea. Your initials gold-stamped on holder, add 50¢ per set.

KELLY FORCEPS So handy for every nurse! 5½" stainless steel, fully guaranteed. Ideal for clamping off tubing. Your initials help prevent loss.

No. 25-72 Forceps . . . 2.75 ea. 6 or more 2.50 ea. Your initials engraved, add 50¢ per forceps.



#### Free Initials and Scope Sack with your own Littmann Nursescope



diaphragm stethoscope . . . a fine precision instrument, with high sensitivity for with high sensitivity for rate. Only 2 ozs., fits in pocket, with gray vinyl anti-collapse tubing, non-chilling epoxy diaphragm. 28° over-all. Non-rotating angled ear tubes and chest piece beautifully styled in choice of 5 jewel-like colors: Goldtone, Silvertone, Blue, Green, Pink."

FREE INITIALS AND SACK! Your initials engraved FREE on chest piece; lend individual distinction and help preual distinction and neith pre-vent loss. Also FREE SCOPE SACK included, worth \$1, as described above right. (Free sacks not personalized; add 50g if initials desired.) Ideal for group gifts! Note big sav-ings on quantity orders (left),

No. 216 Nursescope ... ings on quantity orders (1871), 13.80 ea. ppd.
6-11...12.80 ea. 12 or more ...11.80 ea.
Group Discounts include free Initials and Sack!
"IMPORTANT NEW FEATURE: New "Medallion" styling includes tubing in colors to match metal parts. If desired, please add \$1. ea. to all prices above, and add "M" to Order No. (No. 216M) on coupon. Duty free

MRS. R. F. JOHNSON SUPERVISOR

CHARLENE HAYNES

MRS. HOLBROOK ANN COHN, L.P.N.



SCOPE SACK neatly carries and protects Nursescope or any scope. Double-thick frosted flexible plastic, white vinyl binding. 4½" x 9½". Your own Initials help prevent loss. Na. 223 Sack. . . 1.00 ez. 6 or more 75¢ ea. Your initials gold-stamped, add 50¢ per sack.

#### NURSES PERSONALIZED ANEROID SPHYG.

superb instrument especially A superb instrument especially designed for nurses! Imported from precision craftsmen in W. Germany. Easy-to-attach Veloro cuff. lightweight, compact, fits into soft sim. leather zippored cose 2½/2° a 4° a. 7°. Dial calibrated to 320 mm. Serviced by Reeves If ever required. Your initials engraved on manometer and gold stamped on case FREF, for permanent identification and distinction. A wise investment for a lifetime of dependable service! No. 106 Sphys. . . . 29.95 sa. No. 106 Sphyg. . . . 29.95 ea.



#### CAP ACCESSORIES

CLAN CAP TOTE keeps your caps crisp and clean while stored or carried. Flexible clear plastic, white trim, zipper, carrying strap, hang loop. Stores flat. Also for wiglets, curiers, etc. 8½" dla., 6" high.
No. 333 Tote . . 2.65 ea., 6 or more . . 2.35 ea. Your initials gold-stamped, add 50¢ per Tote.



WHITE CAP CLIPS firmly in place! Hard-to-find white bobbie pins, enamel on fine spring steel. Eight 2" and eight 3" clips included in plastic snap box. No. 529 Clips . . 3 boxes for 1.95, 6 for 3.25, 12 for 49, ea.

#### MOLDED CAP TACS

Replace cap band instantly. Tiny plastic tac, dainty caduceus. Choose Black, Blue, White or Crystal with Gold Caduceus; or all Black (plain). The neater way to fasten bands. No. 200 Set of 6 Tacs. . 1.25 per set. 12 or more sets 1.00 per set



ALL METAL CAP TACS Dainty, jew-elry-quality Cap Tacs with grippers to hold cap bend securely in place. Sculptured metal Caduceus, polished gold finish, clutch fastener. Two Tacs per set, gift boxed, Ideal Class favor or group gift. Add a bit of style to your cap! No. CT-2 Cad. Tacs .....

SEL-FIX CAP BAND Black velvet SEL-FIX CAP BAND Black velvet band material. Self-adhesive, presses on, pulls off; no sewing or pinning. Reusable saveral times. Each band 20" long, pre-cut to popular widths: ¼" (12 per plastic box) ½" (8 per box) ½" (6 per box) ½" (6 per box) 1" (6 per box) 5. Specify width under ITSM column on coupon. No. 6343 Band. . . 1.75 per box



O. DEEVES COMPANY Rox 719 Attichoro Mass 0270

	17511	20100		PD105
ORDER NO.	ITEM	COLUR	QUANT.	PRICE
			_	

Use extra sheet for additional items or orders

INITIALS as desired: . for distinctive identification)

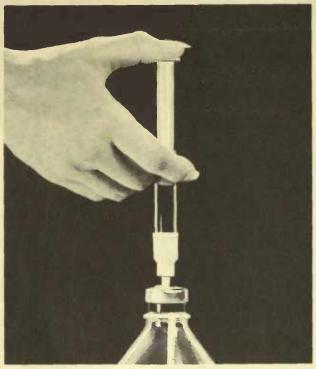
TO ORDER NAME PINS, fill out all information in box top left, clip out and attach to this coupon.

	I enclose \$ (Mass. residents add 3% 5.	7.)
1	Sorry, no CDD's or billing terms available	
	Send to	

Zip

# Here is a new, fast and sterile way to prepare Xylocaine infusions

for life threatening arrhythmias



# **Xylocaine**®

(Lidocaine Hydrochloride Injection, Astra Std.)

ne Gram

- The special 5 ml transfer syringe contains 200 mg/ml Xylocaine and can be added to infusion set-ups without removing solution from infusion flask or bag
- Cuts preparation time in half
- Easy and convenient to use
- Adds another link to the sterility chain
- Disposable
- Clearly labeled for positive safeguard against error

ASTRA Pharmaceutical Division, Mississauga, Ontario



**Next Month** 

# Canadian Nurse

- Gestational Diabetes
- Ten Tips on Preparing Research Proposals
- Health and Community Information Services



#### Photo credits for February 1973

American Journal of Nursing, p. 26 Artwork for Acupuncture Article: p. 28 — Dr. Mifoo Hsu; pp. 27, 29 redrawn from illustrations in Acupuncture: The Ancient Chinese Art of Healing by Felix Mann. William Heinemann Medical Books Ltd., London, Eng. Julien LeBourdais, Toronto, pp. 33-7 Children's Hospital, Vancouver, p. 43 Victorian Order of Nurses,

#### news

(Continued from page 14)

become too knowledgeable and thus more critical of the care they are getting explained Ms. Bieber. These nurses are afraid to risk such a situation in case they are found wanting, she added.

Ms. Bieber suggested five steps nurses could follow in planning patient education: identify the educational needs of the patient and his family, set educational goals for them, choose effective educational methods to be used, carry out the program, and evaluate what they have learned.

Three nurses participated in a panel discussion during the workshop. Margaret Hartley, Swift Current, said health teaching is started by the doctor and nurses must follow through. In her opinion, most nurses are willing to teach health, but have feelings of inadequacy as teachers.

Joy Mitchell, Swift Current, said nurses have as much responsibility in health teaching in a hospital as in a

community.

Cecile Schmidt, Leader, noted that a nurse should instill in her patients a responsibility for keeping themselves healthy. "All they require is the knowledge and skills to do so, and nurses can give these to patients," she said.

All three panelists agreed that generally nurses are not doing a good job

of patient teaching.

**Ontario Heart Foundation Offers** Fellowship For Master's Degree

Toronto, Ont. - The Ontario Heart Foundation offers a fellowship of \$3,000 annually to a qualified registered nurse who is enrolled in the course leading to a master's degree in nursing at the U of Toronto.

The applicant must have been accepted into the master of science in nursing course, and have serious intention of practicing cardiovascular nursing in Ontario following gradua-

In selecting a recipient, the awards committee will review the applicant's nursing record and may request a personal interview.

Application forms are available from the chairman of the awards committee, graduate division of nursing, U of Toronto school of nursing, 50 St. George Street, Toronto 181, Ontario.

Applications should be submitted by June 15. The award is made annually.

## The least you can do for hospitalized diabetics

It's not that you should do more. It's just that KETO-DIASTIX\* Reagent Strips require the least amount of effort in testing for glucose and ketones in urine. Simply dip into urine and get a semiquantitative reading for glucose and ketones in 30 seconds. What could be easier and less troublesome for you and the patient? Useful all around the hospital. On wards, at the bedside, in patient teaching centers, and in the O.P.D. Also, a good test to recommend for the patient to use at home after discharge. Obtain full details on KETO-DIASTIX by calling your Ames Systems Specialist or by writing to the address below. It's the least work you can do in diabetic urine testing.

## **Keto-Diastix**

Ames Company



Division Miles Laboratories, Ltd. 77 Belfield Road, Rexdale, Ontario

"Chemical and biological information systems serving Medicine and Industry"



\*Trademark

p. 44.

# STRETCH

#### your nursing skills with these Saunders texts

#### Asperheim & Eisenhauer: Pharmacologic Basis of Patient Care

**New 2nd Edition** 

Emphasizes not only the basic factual knowledge of pharmacology, but the nurse's role in drug therapy and her position as a vital member of the health team. By Mary K. Asperheim, R.N., M.D., and Laurel A. Eisenhauer, R.N., M.S.N. About 495 pp. Illustd. About \$9.30. Just Ready. Order no. 1436.

### Brown & Fowler: Psychodynamic Nursing

4th Edition

Offers valuable advice and guidance on the use of psychology in nursing, particularly in a psychiatric service. Discusses psychopharmacologic agents and emphasizes nursing in deprived environments. By Martha Montgomery Brown, R.N., Ph.D., and Grace R. Fowler, R.N., M.A. 358 pp. Sept. '71. \$7.50. Order no. 2162.

#### DuGas: Kozier-DuGas Introduction to Patient Care

2nd Edition

How to judge and meet the patient's needs. Common health problems are discussed. Includes behavioral objectives and the nurse's role in diagnostic therapeutic care. By Beverly Witter DuGas, R.N. 487 pp. 157 Illustd. June '72. \$8.25 Order no. 3225.

#### Falconer et al: Current Drug Handbook 1972-74

The latest clinical data on more than 1500 drugs: name, source, synonyms, preparations, dosage, administration, uses, action, contraindications. By Mary W. Falconer, R.N., H. Robert Patterson, Pharm.D., and Edward A. Gustafson, Pharm. 0. 250 pp. Soft Cover. March '72. \$5.40. Order no. 3565.

#### Kron: The Management of Patient Care: Putting Leadership Skills to Work

3rd Edition

Guides to leadership in nursing. Care is discussed along lines of hospital policy, doctor's prescription, and the nurse's decision. By Thora Kron, R.N. 210 pp. Illustd. Jan. '71. \$3.90. Order no. 5527.

#### Bakwin & Bakwin: Clinical Management of Behavioral Disorders in Children

4th Edition

Tells how to better understand and deal with the many behavioral and emotional problems of childhood. Includes common-sense handling of adolescent rebellion. By Harry Bakwin, M.D., and Ruth Morris Bakwin, M.D. 714 pp. Illustd. May '72. \$18.05. Order no. 1502.

#### Keane & Fletcher: Drugs and Solutions

2nd Edition

A Programmed Introduction for Nurses

Simplifies learning calculation of dosages and preparation of solutions by teaching the reader to use simplified proportions. By Claire B. Keane, R.N. and Sybil M. Fletcher, R.N. 171 pp. Soft Cover. Aug. '70. \$3.35. Order no. 5341.

#### Freeman:

#### Community Health Nursing Practice

Introduces modern concepts of community health nursing as a dynamic and socially-oriented discipline. Special attention is given to poverty, family planning, and mental health. By Ruth B. Freeman, R.N., Ed.O. 414 pp. Illustd. Aug. '70. \$7.75. Order no. 3876.

#### Kron: Communication in Nursing

2nd Edition

From lecturing to listening, from writing reports to reading efficiently—a practical guide to effective communication with doctors, patients and co-workers. By Thora Kron, R.N. 299 pp. Illustd. Soft Cover. Jan. '72. \$4.15. Order no. 5521.

### Leifer: 2nd Edition Principles and Techniques in Pediatric Nursing

Over 140 essential procedures, including use of new equipment, development of observation techniques, assessing the newborn, neonatal intensive care. By Gloria Leifer, R.N. 229 pp. 149 Illustd. March '72. \$7.50. Order no. 5714.

In preparation. Ready April. Order no. 6098.

· 2nd Edition

by far the most widely used text of its kind. Totally rewritten and updated to describe the role of the nurse as a member of a team working for the welfare of the child and his family. By Dorothy R. Marlow, R.N., Ed. D.

Specially designed for in-service training. Describes virtually every hospital procedure a nurse can be expected to perform, including advanced procedures that aides perform under supervision such as catheterization and oxygen therapy. By Mary E. Mayes, R.N. 239 pp. tllustd. Soft Cover.

Reed & Sheppard: Regulation of Fluid and Electrolyte Balance: A Programmed Introduction in Physiology

Provides a working knowledge of fluid shifts, solute distributions, electrolyte imbalance, more. By Gretchen M. Reed, M.A., and Vincent F. Sheppard, Ph.D. 317 pp. Illustd. Soft Cover. July '71. Order no. 7517.

Robinson:

Mayes:

Psychiatric Nursing as a Human Experience

Abdallah's Nurse's Aide Study Manual

July '70. \$4.10. Order no. 6190.

Establishing a one-to-one relationship with the patient. Discusses anxiety as a dynamic construct, contemporary problems (alcoholism, drugs, mental retardation), institutional and community health nursing. By Lisa Robinson, R.N. 352 pp. Sept. '72. \$8.25. Order no. 7620.

LeMaitre & Finnegan: The Patient in Surgery: A Guide for Nurses

Sound guidance on surgical preparation, operative techniques, and postoperative care. New material on wound healing, vascular surgery, craniotomy, heart surgery. By George D. LeMaitre, M.O., and Janet A. Finnegan, R.N. 457 pp. 111 tilustd. Soft Cover. Sept. '70. \$6.70. Order no. 5716. Stryker: Rehabilitative Aspects of Acute and Chronic Nursing Care

Special relevance to neuromuscular and skeletal disorders. Includes body mechanics, care after discharge, communication with brain-damaged patients. By Ruth Perin Stryker, R.N. 236pp. 125 illustd. April '72. \$8.00. Order no. 8636.

Sanderson: The Cardiac Patient A Comprehensive Approach

For both surgical and non-surgical patients. Discusses background of problems, then methods of treatment: electrocardiography, cardiac drugs, cardiopulmonary resuscitation, etc. By Richard G. Sanderson, M.D. 7 Contributors. 548 pp. 188 Illustd. June '72. \$11.85. Order no. 7905.

Sutton: 2nd Edition
Bedside Nursing Techniques in Medicine and Surgery

Describes hundreds of basic and specialized nursing techniques for reverse isolation, hypodermoclysis, tubeless gastric analysis, heart transplants, more. By Audrey L. Sutton, R.N. 398 pp. 871 Illustd. March '69. \$8.50. Order no. 8666.

Watson:
Medical-Surgical Nursing and Related Physiology

Reviews relevant anatomy and pathophysiology, applying them to nursing care for disorders of particular systems or organs. Illustrations are of unusual instructional quality. By Jeanette E. Watson, R.N. 786 pp. Iflustd. April '72. \$10.30. Order no. 9135.

Wood:

Nursing Skills for Allied Health Professions

Step-by-step descriptions of basic skills required of all entry-level personnel: body alignment, bedmaking, oxygen therapy — 184 in all explained in 36 self-study units. Edited by Lucille A. Wood, R.N. 2-vol. 768 pp. 560 illustd. May '72. \$10.30. Order no. 9600-1.

W.B. SAUNDERS COMPANY CANADA LTD.  833 Oxford Street, Toronto 18, Ontario						
NAME	1436 1502 2162 5341	3225 3876 3565 5521	□5527 □5714 □6098 □6190	☐ 7517 ☐ 7620 ☐ 5716 ☐ 8636	7905 8666 9135 9600-1	
NAME	•••••	PPAV			ZONE	CN 2-73

# Pampers Pampers oives ouboth abreak

# Keeps him drier

Instead of holding moisture, Pampers hydrophobic top sheet allows it to pass through and get "trapped" in the absorbent wadding underneath. The inner sheet stays drier, and baby's bottom stays drier than it would in cloth diapers.



# Saves you time

Pampers construction helps prevent moisture from soaking through and soiling linens. As a result of this superior containment, shirts. sheets, blankets and bed pads don't have to be changed as often as they would with conventional cloth diapers. And when less time is spent changing linens, those who take care of babies have more time to spend on other tasks.

PROCTER & GAMBLE

# Coronary patients and their families receive incomplete care

The author studied what selected patients and their families knew and how they felt about myocardial infarctions and the treatment prescribed during the acute and early convalescent phases of the illness. She concluded that nurses need to assist patients and their spouses to adapt to heart disease, by identifying and meeting their learning needs at all the stages of illness and recovery.

Joan Royle, RN, M.Sc.N.

"When your life is at stake, you are left to guess what is best for you," said Mr. A., a well educated gentleman in his fifties, who was in the early convalescent period following a myocardial infarction.

In the one week following discharge from hospital, Mr. A. developed a rigid daily routine based on his medication schedule. Although this routine proved inconvenient, he was unable to change from the time-schedule established in hospital.

Mr. A. remained in bed each morning after his wife left for work, until the

Red Cross homemaker arrived. He reported feeling tense when alone in the house and preferred not to move around. Anxiety regarding physical activity was further evidenced by Mr. A.'s reluctance to venture past his bedroom and study, even when members of his family were present.

Incidents such as this pose several questions for health personnel. Why did Mr. A. respond in this manner to his heart disease and prescribed therapy? What were the bases for his fears and anxieties? How can health personnel assist patients and their families to adapt to heart disease, which, although acute in nature, is a chronic disease with lifetime implications?

Satisfactory rehabilitation of a patient following myocardial infarction depends on his adjustment to the physical limitations and psychological problems related to the underlying cardiac disease. To assist patients and their families to move toward useful lives that accommodate the illness, nurses and other health personnel

The study reported in the article is the subject of Joan Royle's thesis for the M.Sc.N. degree, which she received from the U of Toronto in 1972. She was awarded an Ontario department of health bursary for master's degree study. Ms. Royle is a graduate of the McMaster U School of Nursing (B.Sc.N.) and is now a lecturer at McMaster, teaching medical-surgical nursing in year 111.

require knowledge of an individual's learning needs and of factors affecting responses at different stages of illness.

#### The literature

Available knowledge concerning the educational needs of patients and their families following myocardial infarctions rests upon conclusions drawn from studies of widely varying orientation and quality. Few investigations have attempted to identify what the patient knows about his disease and therapy or his attitude to these.

Studies have indicated that during the acute phase of illness most patients show denial of heart disease and fear of death.1 The threat to life and the complexity of the disease and its treatment result in patients becoming dependent on others to meet their needs. Knowledge becomes irrelevant or unnecessary to the dependent patient who has not yet acknowledged his illness; information given is not retained.2 Investigators suggest the increased anxiety, identified in patients during periods of transition in care, may be decreased by preparation of the patient for transfer and discharge.<sup>3</sup>

Few patients have been found to succeed in altering health habits that may adversely influence their coronary disease. Several follow-up studies of patients with chronic illness have demonstrated the great frequency with which patients fail to follow medical recommendations. Investigators agree in attributing this lack of compliance with prescribed health regimen to inadequate information about the illness and treatment and failure to understand the little information that was given.

The influence of the family in assisting the patient to accomplish the tasks of reorganization and rehabilitation was illustrated by Donabedian's

findings that patients who had help available to them in the home were more likely to comply with medical recommendations.<sup>5</sup>

The effectiveness of patient and family education is influenced by the role expectations of members of the health professions, their preparation for teaching, and the system in which they function. The nurse can set the climate for patient teaching in both the hospital and the community; she also has many opportunities to teach patients and their families.

#### The study

Patients and their families require specific knowledge, at different stages of adaptation following myocardial infarctions, to enable them to comply with prescribed therapy and adjust to the changes in life style resulting from the heart disease. To identify the learning needs of patients and their families more information was needed. A study was undertaken to describe what selected patients and their families knew and how they felt about myocardial infarctions and the treatment prescribed during the acute and early convalescent phases of illness. The ultimate purpose was to improve nursing care through more effective patient and family teaching.

Twenty patients with myocardial infarctions were interviewed in the coronary care units and on the general care units of two large hospitals; seventeen of this sample were interviewed again five to ten days following discharge from hospital. Six of the patients' spouses were interviewed during the early posthospital period.

Because the sample was selected, findings cannot be generalized beyond the study population, but they do illustrate many important implications for nursing practice.

**Findings** 

Initially, the patients and their spouses showed an awareness of the diagnosis but their abilities to accept this were influenced by their attitudes of fear, denial, and anger. During the acute and early convalescent phases of illness, most patients did not understand the causes of heart disease or the pathophysiological changes following the myocardial infarction. The same misconceptions were apparent in their responses throughout the three interviews. Patients with previous history of heart disease showed a similar lack of understanding about their illness.

During the initial period at home, patients and their spouses showed attitudes of acceptance of their changed situation but, for most, this was accompanied by an element of fear. Three in ten patients showed additional attitudes of defeat and resignation toward their changed life styles. One in four patients and one spouse in six continued to disregard the illness and changed life pattern.

Preexisting occupational and family problems, limited support from family members or lack of understanding appeared to contribute to continued failure to follow prescribed therapy and/or continued denial of illness. During the later period of hospitalization and the initial period at home, most patients tended to explore the implications of their changed situations, but few appeared to arrive at decisions.

One in two patients with a first infarction showed an attitude of help-lessness while in the coronary unit. Their responses indicated feelings of dependency and lack of perceived ability to influence what was happening to them. Three in four patients gained reassurance from the cardiac monitor, and three in five showed some understanding of the reasons for its use.

TABLE I

### Attitudes of Patients Toward Their Prescribed Medications, Activity Regimen, and Dietary Measures During the Initial Period at Home

Categories of Attitudes Toward Specific Therapeutic Measures	Prescribed Medications (N=15) No.	Activity Regimen (N=17) No.	Dietary Measures (N=13) No.
Acceptance Followed instructions about this aspect of therapy	14	2	3
Acceptance with Fear Expressed anxiety about this aspect of therapy but followed instructions as well as able	0	12	7
Defeat and Resignation Showed additional responses of depression toward situation in regard to this aspect of therapy		6	
Rejection Disregarded some instructions about this aspect of therapy.		3	

Most patients and their spouses indicated acceptance of and reassurance from the coronary care unit environment.

Periods of transition, such as transfer and discharge, appeared to cause stress in most patients; four in five patients reported fear, and one in two patients indicated the additional element of helplessness or lack of ability to control the change. Apprehension about discharge was shown by one in two patients.

Patients acquired only limited knowledge of their prescribed therapy. Most described the instructions they received in vague terms, and few were able to give any reasons for prescribed therapeutic measures. Many misconceptions were found in the patients' responses to questions about the reasons for therapy, which appeared to originate mainly from unpredictable sources such as newspaper articles, friends, and other patients.

Patients tended not to request specific information during hopitalization, but stated they wanted and/or expected to receive information about their heart disease and its effects on their future life styles prior to their discharge from hospital.

Table 1 indicates the attitudes of patients toward their prescribed medi-

cations, activity regimen, and dietary measures during the initial period at home.

#### Patients at home

During the initial period at home, most patients reported following their prescribed therapy. Acceptance of therapeutic measures was combined with fear for most of the patients and their spouses. The major source of apprehension was the limitation in physical activities. Lack of understanding of instructions contributed to this anxiety. One in three patients showed additional attitudes of defeat and resignation toward their physical limitations. Two in three spouses were apprehensive about their ability to follow the prescribed dietary measures.

The experiences of Mr. and Mrs. B. illustrate some of the difficulties study patients and their families encountered in adapting to the heart disease and therapy. For two weeks prior to his admission to hospital, Mr. B. was treated by his family physician for possible angina. This was described as a trying and confusing experience. Neither Mr. nor Mrs. B. knew what was wrong or what to do, and both viewed his admission with great relief.

Mr. B. slept a great deal his first few days in the coronary care unit and remembered little about his care. He indicated that he occasionally watched the monitor and worried when at first it went "haywire" when he moved. He later remarked that nothing bothered him in the unit, including the event of another patient having a cardiac arrest. Nurses described Mr. B. as "a cooperative patient, accepting all that was done for him and following instructions closely."

He viewed his transfer from the coronary unit as necessary, saying, "they must have figured I was ready," but he found his first few days on the general care unit disturbing, Initially he was in a ward where the other patients were noisy and upsetting. He had difficulty sleeping and was moved to a private room.

Throughout his stay in hospital, Mr. B. did not report any desire for information about his heart disease, treatment, or future care. He said he expected to be told before he left. At no time was he able to suggest any causes for his heart disease or to describe the pathophysiological changes resulting from his infarction.

Mrs. B. was reassured by the information she received from the resident in the coronary care unit, but was concerned about the lack of preparation and guidance for the posthospital period.

Following discharge from hospital, Mr. B. received only one medication - digitalis, which he erroneously perceived as being to "thin the blood." He was on a fat-restricted, low sodium diet to which he adjusted readily. Mrs. B. had carefully read the diet sheets and was concerned about her ability to follow them and prepare well-balanced meals. She reported some dietary discrepancies between meals on the part of her husband.

Of greatest concern to Mr. B. and his wife was the extent of physical activity. The uncertainty and concern associated with a new activity frequently resulted in argument and confusion over what he should and should not be

Mr. B.'s family physician was away and, therefore, Mr. B. was unable to contact him for another three weeks. Both Mr. B. and his wife had many questions to discuss with the doctor, including problems of physical activity, diet, sexual relations, and the significance of the "odd thickness" in the chest Mr. B. occasionally experienced.

Mr. B. reported receiving almost no instructions prior to his discharge from hospital. He asked few questions while in hospital and, as a result, knew little about his illness and care. Mrs. B. perceived her role as providing a happy relaxed home and helping her husband to follow his treatment regimen. She recognized the tension created by their insecurity over Mr. B.'s activity regimen, diet, and other aspects of care.

One week following discharge, Mr. B. had made no plans regarding his return to work and perceived no difficulties in returning to his previous job as a construction worker.

#### Implications for nursing

Patients' apparent lack of concern for specific information about their heart disease and prescribed therapy during hospitalization does not negate the importance of this knowledge. The infrequency of requests for specific information may have resulted from insufficient understanding or fear of what they needed to know.

Some patients tended not to ask questions but indicated that they wanted and/or expected to receive information prior to discharge from hospital. Their inability to take the initiative in seeking necessary information was influenced by the stage of adaptation to illness and by their apparent dependency on medical and nursing personnel during

hospitalization.

Nurses should understand the physiological implications of the patient's psychological stress. Fear and apprehension were indicated by most patients on admission to hospital, and in relation to transfer and discharge. Information about the heart disease, hospital environment, and therapy, as well as better preparation for transfer and discharge, should decrease the emotional stress shown by patients during hospitalization and following return home.

The failure of health personnel to identify and meet the patients' learning needs probably contributed to their tendency to seek information from nonprofessional sources, resulting in the development of misconceptions about their illness and care. The misgivings expressed by the patients' spouses and the lack of information they received regarding posthospital care probably hindered their ability to provide the support needed by most patients.

Patients with previous history of heart disease appeared to be more aware of the effects of their illness on their families, resulting in a family becoming a cause for concern rather than a provider of support. Preexisting occupational and family problems appeared to assume greater importance to some patients and probably hindered

their ability to cope with the illness and its residual effects. This illustrates the importance of knowing the patient as an individual and understanding

his past experiences.

Variations in specificity of instructions appeared to account, at least in part, for attitudes of apprehension during the initial period at home. Patients reported they received fairly specific instructions regarding medications, which were clearly written on the medication bottles. Dietary restrictions were described in general terms but were accompanied by printed instruction sheets. Instructions about physical activity were vague and included: "take it easy," "slow down," and "be your own guide."

It would appear from these findings that much of the anxiety found in the patients and their families during the initial posthospital period could have been prevented by health personnel. If instructions given patients and their spouses prior to discharge had been more specific, and if continuity of care had been provided following discharge, patients and their families would have

felt less anxious.

#### **Educational programs**

There is need for more effective individual patient and family teaching and for the development of educational programs for groups of cardiac patients and their families, both in the hospital and on a continuing basis in the community. There is also a need to develop and make available authoritative reference material for patients and their families. This literature is required to reinforce and supplement teaching, to provide a written source of reference when patients are uncertain about their instructions, and to decrease patients' need to obtain information from the news media and friends.

Assisting the patient and his family to understand the patient's illness and therapy is a nursing function, in collaboration with other members of the health team. Continous evaluation and revision of patient teaching is essential to allow for changes in the patient's level of knowledge and need for different information during each phase of illness. Patient and family participation in the development and implementation of the teaching program should increase as the patient progresses toward recovery. Inservice education programs can better prepare nurses in the hospital and community for their teaching roles.

The use of clinical nurse specialists contributes to the improved quality and coordination of patient care and education. These nurses possess the knowledge and ability to assess patients' needs and to plan, implement, and coordinate patient and family education during hospitalization and the initial period at home. The clinical nurse specialist can also assist nursing staff to develop their teaching skills. Most of the nursing needs of the patients and family members during the initial time at home can be met by public health nurses or nurse practitioners with preparation in coronary care and patient teaching.

Nurses with special preparation in coronary care and patient teaching can develop and implement formal educational programs for groups of patients and their families in the hospital and the community. Effective programs would require cooperation among the nurse coordinators; physicians; nurses in the coronary units, general care units, and the community; dietitians; and other health personnel.

Coordination of hospital and community teaching programs can be assured by the use of the same personnel in both programs and/or the establishment of effective lines of communication between the two groups. Continuing programs for patient and family educa-

tion following discharge from hospital could be conducted either in the hospital or in community health centers.

#### Summary

The findings indicated that the needs of study patients and their families for relevant information about their heart disease and prescribed therapy were not adequately identified or met during their hospitalization or initial period at home. When specific instructions were given to patients and their spouses about prescribed therapeutic measures, they experienced less anxiety during the initial posthospital period. When instructions were vague, increased anxiety was shown.

The patients progressed through identifiable phases of adaptation to illness with different kinds of information needed in the coronary care unit, on the general care unit, and at home. Some information provided within a few days of discharge was more meaningful than when given during the initial acute phase of illness.

Attitudes of most patients showed a recognizable pattern from the initial inability to accept the diagnosis to gradual acceptance of their heart disease and its residual effects. Fear and apprehension continued to influence patients' and families' adjustments during the initial period at home.

As nurses, we need to recognize our responsibilities as health teachers, to prepare ourselves to fulfill this role in the hospital and the community, and to develop means of ensuring accessibility and continuity of care and teaching for patients and their families, through all stages of illness and recovery.

#### References

1. Hackett, T.P., et al. The coronary-care unit. An appraisal of its psychologic hazards. *New Eng. J. Med.* 279:12:1367-8, Dec. 19, 1968.

- 2. Graham, L.E. Patients' perceptions in the C.C.U. Amer. J. Nurs. 69:9:1922, Sep. 1969.
- 3. Ibid., p. 1922.
- Donabedian, A. and Rosenfeld, L.S. Follow-up study of chronically ill patients discharged from hospital. *J. Chron. Dis.* 17:9:857, Sep. 1964.
- 5) 1bid., p. 853.

# Acupuncture

Acupuncture points are electrically distinguishable from adjacent tissues. And, when a point is stimulated, the meridian which is formed by acupuncture points registers a corresponding change in electrical potential. Maybe there is a scientific basis for this mysterious therapy.

Margaret E. Armstrong

Acupuncture, an unfamiliar term in this country barely a year ago, is becoming a meaningful word to health professionals and laymen alike. It will probably be some time before detailed information is readily available concerning the theoretical basis and practical application of acupuncture. However, enough is now known to begin acquisition of knowledge and assessment of implications of this ancient medical practice. Only if we begin now, will the nursing profession be able to determine its own destiny regarding its role in relation to acupuncture and related techniques.

#### **Puncture** points

The term acupuncture derives its meaning from the Latin acus, needle, and punctura, a puncture. It is a method of preventing, diagnosing, and treating disease by inserting metal needles into the body at designated locations—acupuncture points—at various depths and angles.

There are now approximately 1,000 known acupuncture points, each nearly one-tenth of an inch in diameter which, in pathologic conditions, become tender when pressure is applied. Any given disease may affect one or several points and the groupings may differ from patient to patient.

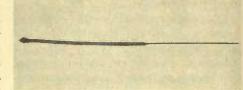
Acupunture points, also known as "hoku points," do not exist in isolation;

they form essentially 14 groups. The points in each group are arranged in a line known as a meridian, which is associated with an internal organ. A meridian runs along one of the major parts of the body and terminates at the tips of the fingers or toes. Each meridian is paired with another meridian located on the other side of the body.

The pain or sensation indicating disease in that organ is registered along the path of the meridian for that specific organ.<sup>2</sup> For example, the pain commonly felt in angina pectoris runs along the course of the heart meridian which runs down the inside of the arm.

Other meridians are associated with

Ms. Armstrong is a predoctoral candidate in the department of physiology and biophysics, University of Washington, Scattle. She enrolled in a course in acupuncture at the Experimental College of the University of Washington because "... it seemed to provide a unique opportunity to explore the theory and techniques of the oriental medical practice as a basis for neurophysiological research in the future." Ms. Armstrong received her B.S.N. from Wayne State University School of Nursing, Detroit, and her M.S. from the University of California, Berkeley. Ms. Armstrong expresses her thanks to Dr. Mifoo Hsu, an acupuncturist, for his review of portions of this paper.



Acupuncture needle, shown in actual size, is rotated and inserted downward for treatment.

the pericardium, lungs, large and small intestines, stomach, spleen, diaphragm, liver, gall bladder, kidneys, bladder, circulation, and with the function of nervous energy and warmth.

Acupuncture needles are very fine slivers, about 1/100 inch in diameter, and have been made of wood, bamboo, gold, silver, and various other metals. Today, they are usually made of stainless steel, varying in length from one to seven inches with a wire wrapped around the blunt end to aid in handling. They are like a fine sewing needle, rather than the hollow needles used for injections.

Most commonly, the needle is inserted by rotating it between the thumb and index finger using slight pressure

Copyright Sept. 1972, The American Journal of Nursing Company. Reprinted from *American Journal of Nursing*.

in a downward direction. The speed and angle of rotation depend upon the intensity of the desired stimulation. The method for insertion is determined in part by the angle and depth of insertion to be used as well as the duration and frequency of the treatments. At this point, one may logically conclude that acupuncture is totally irrational and ought to be discarded in modern medical or nursing practice. But, there is a long history of its use in Western Europe as well as in Asia, indicating, perhaps, that it has proved helpful through the years.

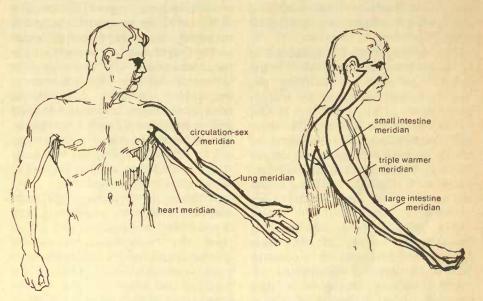
#### Restoring the balance

The date of the origin of acupuncture is an approximation at best, but the practice probably began nearly four to five thousand years ago in China. It was introduced in Japan 2,600 years ago <sup>3</sup> In China its development reached a peak by the mid-1800s and then steadily declined as a result of increasing western influence, initially by Jesuit missionaries and then by medical doctors.

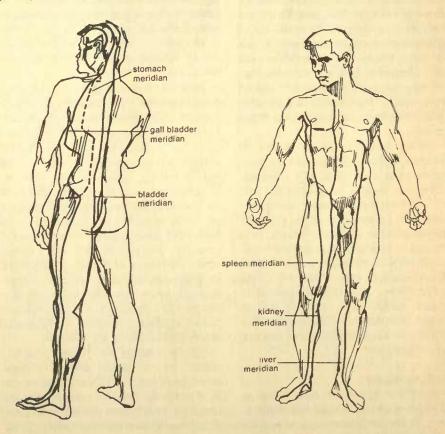
However, the practice continued to develop in Japan and Korea, and returning missionaries and doctors introduced acupuncture to Europe—principally France, Germany, and Holland—and England.<sup>2</sup> With the beginning of the Chinese People's Republic in 1949, interest in acupuncture in China was rekindled in order to bring health care to the millions of people who were without readily available medical services.

Modern western medicine and traditional oriental methods, including acupuncture, are now used in an increasingly integrated fashion in China and Japan. In 1956, the U.S.S.R. sent several doctors to China to study acupuncture, consequently stimulating extensive research, education, and practice in the U.S.S.R.

Thus, acupuncture is now an integral part of the basic medical education in China, Japan, Southeast Asia, and



Acupuncture points form meridians that correspond to internal organs. Cardiac pain, for example, is registered along the heart meridian.



Russia. There are also acupuncture societies, journals and practitioners throughout Europe and Scandinavia. Cooperation and exchange of research is carried out through annual meetings of the International Congress of Acupuncture and Moxibustion. There are relatively few doctors in Canada and the United States, however, who have incorporated acupuncture into their medical practice.

The development of acupuncture in China has been deeply embedded in the oriental philosophy concerning the balance in the universe of the antagonistic forces of Yin and Yang. In Old China, the people believed that these two forces had to be in balance for health to exist. Disease and, consequently, meridians and acupuncture points were classified according to the characteristics of the Yin and Yang philosophy.

The ancient Chinese also believed that Qi, the energy of life, flows through the meridians in a constant flux which must be maintained for health to exist. A blockage of Qi, they believed, caused an excess in certain areas of the body, resulting in a disease corresponding to the sites involved.<sup>4</sup>

For believers in Yin and Yang, the universe is thought to be made up of five basic elements which have a distinct relationship to one another, and thus maintain a balance for all existence. Organs, emotions, senses, and all other entities are classified according to the interdependence of these basic elements.

Viewing health care in terms of balance is difficult for us until we consider specific examples. For instance, acupuncture is used to restore the balance between sympathetic and parasympathetic innervation of the stomach in the treatment of gastric ulcers. It is also used to maintain or restore the balance of the five to one ratio of sodium and potassium necessary for electrolyte balance. When it is thus illustrated in our own terminology, we are able to visualize the ancient philosophy of Yin and Yang as used practically in modern medical practice.

#### Practicing the art

Preventive medicine has been an important part of oriental life for centuries. A doctor commonly was paid

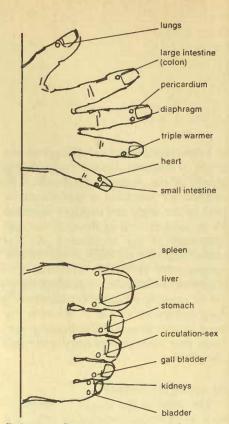
by the patient when he was healthy; payments ceased when the patient became ill. The doctor provided medicine and treatment as needed during illness free of charge.

Today, an assessment, recommended yearly although frequency varies with availability of medical services, is made to determine early signs of disease. The skin's resistance to electric current is measured on acupuncture points located on the fingers and toes as illustrated in the chart shown. 5 A 50 percent or more difference between the readings of the paired meridians indicates the need for treatment to restore a balance before symptoms of pathology appear. It is believed that increase of pathology can be prevented during the very early stages of disease when it is difficult to determine a specific diagnosis.6

Although modern diagnostic techniques are used in conjunction with acupuncture, emphasis is also placed upon interviewing the patient and observing colors, odors, and emotions in great detail. The face, especially the forehead and below the eyes, and the inner aspect of the foream are carefully examined for abnormal coloration. It is also believed that any changes in the sense organs are related to changes in one of the body organs. Vocal expressions, odors, secretions, and emotions are all thought to be related to specific functions.

Auscultation and palpation in oriental medicine are performed to a much greater extent than in western medicine. In fact, palpating pulses has been developed to a fine art; various disease entities have been associated with the pulses felt by using varying amounts of pressure and at slightly different locations on the radial artery. There are probably 48 different pulses over the body, but at the location of the wrist over the radial artery there are 2 pulses at six locations for a total of 12 pulses. In diagnosis and in subsequent evaluation of acupuncture treatments, approximately 27 qualities of 12 different pulses in three positions on the radial artery of each hand are assessed.

"If the ball of the finger is lightly placed on the radial artery in these three positions, it will be noticed, except in a perfectly healthy person, that the sensation is different at each place, and if gradually a greater pressure is ex-



Points on fingers and toes can be measured electrically to detect disease.

erted, suddenly a point is reached where the sensation has a totally different quality. This is the deep position. The superficial position has been compared to the elasticity of the arterial wall, and the deep position to the sensation of the flow of blood within the artery. It has been suggested that the pressure required for the superficial pulse is the diastolic pressure, while that for the deep pulse is the systolic pressure."7 Consistent practice is required to make a detailed assessment of these pulses. The illustration on the next page indicates the relationships that are believed to exist between the deep and superficial pulses and internal organs.

Recently in China, there has been an attempt to treat deafness by acupuncture, especially that caused by childhood disease. Many schools for deaf and mute children have had impressive results with recently developed techniques.

Not all diseases, however, have been effectively treated with acupuncture. Theoretically, it is possible to help or cure any disease that can be affected by a physiologic process. A problem that is purely anatomic or advanced to the stage of being uninfluenced by a physio-

logic process, such as a kidney stone, advanced osteoarthritis, or a fully formed cataract, cannot be treated success-

fully by acupuncture.

Considerable publicity has been given to acupuncture as an anesthetic for surgical and dental procedures as well as to its use as an analgesic for postoperative pain. Local and spinal nerve blocks, as well as inhalation anesthesia, are commonly used in China. However, acupuncture for anesthesia, using one or several needles, is an alternative for most surgical procedures with the possible exception of abdominal surgery when extensive manipulation of abdominal viscera is involved.

Approximately 20 minutes prior to surgery, the needle or needles are inserted into the area for the particular procedure and are rotated manually or connected to a battery-operated pulsator.9 During surgery, the patient is able to converse with the doctors and nurses, or read. Fluids and fruit are offered to the patient, and he is frequently allowed to walk from the operating room to his hospital room.

As anesthesia, acupuncture has several advantages over other types of anesthesia. With acupuncture, blood pressure is not lowered and respiratory tract complications do not occur postoperatively. There is no interruption in the patient's hydration and no postoperative nausea or vomiting. The patient's pain threshold in increased, making it possible to perform minor procedures associated with the surgery without additional anesthesia.

The term moxibustion is frequently used in the literature on acupuncture. Moxibustion, which is stimulation of the acupuncture points by heat, may be used alone or as a supplement to acupuncture and uses acupuncture principles, although it is more generally applied for chronic illnesses. 10 In this technique, sticks or cones made from pulverized artemisia vulgaris (wormwood) are placed over the acupuncture point and are ignited and permitted to burn down to or close to the skin.

#### Understanding the art

There is no apparent explanation of why the insertion of needles or the application of heat on the surface of the body should have any, much less definitive and predictable, results in areas and functions far removed from the treatment site.

Commonly, hypnosis, autosuggestion, cultural and political influence, or some aspect of quackery are given as explanations. Yet, one needs only to survey the results of extensive research in many countries in which the same effects of acupuncture are found in several animal species to realize that these initial answers are not adequate. Indeed, acupuncture is widely used in veterinary medicine for the same purposes as described here for humans.

In looking further for a theoretical basis, it is necessary to sort out aspects of oriental philosophy and superstition from objective data which can be observed, recorded, and analyzed. As theories develop to scientifically plausible levels, one can then look back to ideas of the past and recognize correlations, unhindered by emotional barriers, formed by words and ideas strange to our culture and education.

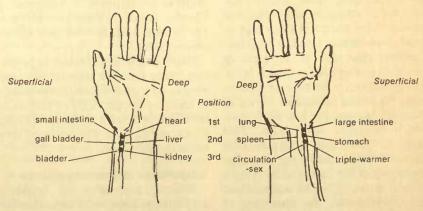
Several possible theories have emerged from research activities, mainly in China, Japan, and Russia. In 1893, Sir Henry Head, a British neurologist, published the observation that pain resulting from pathology of various organs was often referred to clearly definable areas on the body surface. These areas, which came to be known as "Head's zones," are similar to the location of the acupuncture meridians associated with the same organs. In 1883, independent of acupuncture research, Dr. Weihe claimed he had discovered 195 points in close proximity with the viscera — points quite similar to acupuncture points. Both of these discoveries contributed to the development of therapeutic anesthesia including nerve blocking via injection of a local anesthetic for relief of somatic or visceral pain.11

There is also a relationship between the arrangement of the meridians and the various layers of cells in the earliest stages of embryonic development. Detailed examination of this relationship reveals inconsistencies, but there is sufficient correlation here to warrant further study.

Another possible relationship may exist between Bonica's theory of trigger points and acupuncture. According to his theory, injury or pathology in muscles causes tenderness not only in the involved muscles themselves, but also in their tissues and associated organs, and the resulting increase in tension causes stiffness and increased tenderness in the muscles.12 Moreover, Bonica contends that this type of local pain may be projected to other locations as referred or radiating pain.

The gate control theory of pain by Melzack and Wall is another possibility to consider. This theory stems from their discovery that two types of nerves are stimulated when a pain-evoking agent, like a needle, is applied.<sup>13</sup> The fine nerves (delta fibers which are small, myelinated, type A neurons) transmit the pain sensation to the appropriate location in the spinal cord

Positions of Pulse Diagnosis



Diseases can be detected by using varying pressures on the pulses at the radial artery. There are six locations which correspond to internal organs.

and then to the brain. The other fibers (unmyelinated C fibers) are thicker and have an inhibiting effect on the finer ones. Perhaps, because of their larger size, sensory impulses which the thicker fibers conduct arrive at the spinal cord first and close the gate for the sensation of pain carried by the fine nerves. Thus, activity in the larger peripheral sensory nerve fibers carrying nonpainful impulses inhibits pain conduction in the spinal cord from the smaller fibers. According to these authors, pain centers in the brain may then be jammed by the messages of minor pains, such as from acupuncture needle insertions, thereby decreasing awareness or sensation of the more major pain which occurs in surgery.

Dimond reports that researchers in China used electrophysiologic techniques in rabbits and by peripheral pain stimulation produced a standard "induction voltage" in the cerebral cortex of one to two mm. in height. (This measurement is not recorded in the usual manner but may represent that used in China.) According to Dimond, "Acupuncture when placed appropriately had proved to lower this cerebral induction voltage" in the cerebral cortex though the painful stimuli application continued.... Using humans and a standard stimulation of the tooth as the pain stimulus, they [the Chinese research team I found evidence that the recognized 'tooth' acupuncture anesthesia point on the back of the hand, near the attachment of the thumb, would effectively eliminate this pain stimulus to the patient."14

A number of independent investigators have found that acupuncture points have characteristic electrical properties. The electrical resistance of tissues is consistently lower at acupuncture points than that at surrounding tissues; that is, there is a decrease in the skin's resistance to the flow of electric current. Electrical resistance varies at acupuncture points, but it is fairly consistent over other skin areas. change in electrical charasteristics seems to be influenced by the physiologic processes of the body and by certain emotional states. When an acupuncture point is stimulated, the resistance of other points along the corresponding meridian is also affected. However, these changes along the meridian

are transmitted more slowly than are nerve impulses. If the anatomic meridian is cut, the stimulus of an acupuncture point on that meridian is not transmitted to acupuncture points beyond the cut. Similarly, the internal organ with which the meridian is associated is not influenced by the treatment.

These electrical characteristics disappear in patients who have indergone electric or x-ray therapy. But, almost with this sole exception, the acupuncture points can be detected by their electrical resistance measured in microamperes.

Additional confirmation comes from the work of the Kirlians, a Russian couple, who have developed a method of producing photographs from the action of high-energy frequency currents. In this method, nonelectrical properties of the object being photographed are converted into electrical ones through the action of a field with a directed transfer of charges from the object to a photographic plate or screen. This method, now called Kirlian Photography, shows emission of energy from the specific areas traditionally called acupuncture points.

A Korean physiologist claims to have found distinct anatomic characteristics which coincide with acupuncture points and meridians. These points are said to "... consist of groups of small oval cells surrounded by many blood capillaries." The structures connecting one acupuncture point to another "... consist of clusters of thin tubular cells with round or oval cross-sections, and having a diameter of 20 to 50 microns." Attempts by a Chinese research team to confirm the results of this study have thus far been unsuccessful.

Much research still needs to be done. But, many possible theories are beginning to emerge and perhaps the anatomic and physiologic basis of this ancient technique will soon be firmly established or rejected on the basis of sound research endeavors.

#### Acupuncture and nursing practice

Several principles of traditional acupuncture are akin to ideas that nursing has been advocating for many years: the importance of preventive health measures, active involvement of the

individual patient, detailed observations, and patient teaching are but a few examples. In addition, most references concerning acupuncture stress the importance of the whole man, in whom nothing happens in isolation but in relationship to other events occurring in his internal or external environment. Consequently, there are specific areas within the context of these concepts which have relevance to nursing practice.

Nurses, I believe, are often applying acupuncture principles directly and indirectly and have been doing so for some time. For example, acupuncture points have been used to develop massage techniques by schools of massage throughout the world. Massage used to produce results proximally or distally to precise points of cutaneous stimulation may be called reflexogenous. These fall into two groups: spontaneously painful points and points selected by the therapist. These correspond to acupuncture points and are treated with the hand instead of the needle. 17 Nurses have generally used massage techniques for a local or regional effect or a general feeling of well-being and relaxation.

Since several meridians run longitudinally along the back, neck, and buttocks, studies need to be carried out to determine what effects the massage techniques commonly employed by nurses have upon specific functions far removed from the site of massage. And, what are the distant effects of local heat treatment applied for local results? Compiling such information will aid in planning the procedures needed for desirable and predictable results as well as in avoiding the problems we may have dismissed in the past as being unrelated to a particular procedure.

A natural question arises as to the possibility that we are stimulating known acupuncture points when administering injections, starting intravenous feedings, or withdrawing blood. It now appears that if the common injection sites are correctly chosen, the major acupunture points in the area can be avoided.

Common injection sites on the buttocks, anterior thighs, and below the iliac crest are examples. The bladder meridian runs longitudinally down the midline of the gluteus maximus muscle

leaving the inner aspect of the upper outer quadrant free of major acupuncture points. The midline of the anterior thigh is also void of points. The gall bladder meridian runs down the outer aspect of the thigh, but swings anteriorly below the iliac crest leaving the vshaped area commonly used for injections free of points if the injection site is not in the extreme anterior portion of the v.

Numerous meridians are located in the abdominal area and in the anterior and posterior surfaces of the forearm and hands. Thus, a detailed study of meridians must be done to determine the more important areas to avoid when inserting a needle for whatever purpose in these areas. It is possible that persistent pain or sensation following an injection may be due to stimulation of an acupuncture point with physiologic results in the corresponding organ.

It is also interesting to note that acupuncture points are located on the tips of the fingers. In acupuncture therapy, these points are treated in tonsillitis, fever, sunstroke, meningitis, and intestinal influenza. In patients with high fever, a quick jab with a triangular needle is made with removal of several drops of blood. What effects, then, if any, are brought about by the method commonly used to obtain blood in capillary tubes for hematocrits?

Attempts are now being made to assess the use of acupuncture in this country. 18 In New York City, a ten-man committee of medical specialists to conduct and coordinate acupuncture studies has been formed. Elsewhere, several doctors and medical groups, such as the National Academy of Sciences, have attempted to initiate cooperative research with practitioners in China. And some attempts are being made to seek information from practitioners in this country. In Seattle, for example, approximately 45 doctors and other health-related professionals have attended a survey course in acupuncture being taught at the University of Washington's noncredit Experimental College. The 14-week course is taught by Professor Mifoo Hsu, a retired acupuncturist who has taught and practiced in Hong Kong and Japan.

In preparation for increased practice of acupuncture, the Teamsters

Union in San Francisco recently decided to include acupuncture coverage in its health insurance policy. 19 This may be one of the first steps toward popularization of the practice of acupuncture in the United States [and Canada].

Thus, the process of inquiry has already begun in this country into a medical practice that is thousands of years old and embedded in a culture vastly different from our own. To discard or accept acupuncture as a sound medical and nursing practice would be wrong at this time. Open-mindedness with a proper degree of caution would be most helpful while we investigate the practice of acupuncture and related techniques with the hope of making discoveries which will eventually improve nursing care.

Implications for nursing research have been implicit throughout this discussion. As interest in acupuncture increases, nurses and other health professionals can provide accurate information to laymen, and to one another, to avoid inappropriate and overzealous use of acupuncture. As the valid uses of acupuncture are determined, nursing can play a valuable role in judicious integration of these techniques into nursing and medical prac-

#### References

- 1. Mann, Felix. Acupuncture; the Ancient Chinese Art of Healing. New York, Vintage Books Edition, 1972. pp. 10-12. (Originally published by Random House, Inc., 1963.)
- 2. Hsu, Mifoo. Survey course of acupuncture, 1971-1972. Seattle, Wash., University of Washington, Experimental College, 1972.
- 3. Hashimoto, M. Japanese Acupuncture, edited by P.M. Chancellor. New York, Liveright Publishing Corporation, 1968.
- 4. Mann, op. cit., p. 10.
- 5. Hsu, Mifoo. Form MH 1001.
- 6. Schreiber, Connie. Syracuse Herald-J. Mar. 21, 1972, p.1.
- 7. Mann, op. cit., p. 79.
- 8. Schreiber, Connie. Mutes regain their speech. China Reconstructs, 21:2, Feb. 1972.
- 9. Dimond, E.G. Acupuncture anesthesia; Western medicine Chinese traditional medicine. JAMA 218:1558-1563, 1971.

- 10. Stovickova, Dana, About moxibustion. Far East Reporter :31, Mar. 1972.
- 11. Wallnofer, Heinrich, and Von Rottauscher, Anna. Chinese Folk Medicine. New York, Crown Publishers, 1972, pp. 121-122.
- 12. Bechterev, V.M. Acupuncture research in U.S.S.R. J. Int. Congress Acupuncture and Moxibustion. 15:272-274, 1965.
- 13. Melzack, Ronald and Wall, P.D. Pain mechanisms; a new theory. Science 150: 971-979, Nov. 19, 1965.
- 14. Dimond, op. cit., p. 1563.
- 15. Kirlian, S.D. and Kirlian, K. Photography and Visual Observation by Means of High-Frequency Currents. (Federal Technical Report, FTD-TT-62-1549/1+2+4, Sept. 19, 1959.)
- 16. Mann, op. cit., p. 172.
- 17. Huard, Pierre and Wong, Ming. Chinese Medicine. New York, Mc-Graw-Hill Book Co., 1968, p.222.
- 18. Kramer, Barry. Wall Street J. Mar. 29, 1972.
- 19. Randel, Judith. Orlando Sentinel. Mar. 16, 1972, p.1-C.

# **Health care at Toronto** International airport

Nearly five million persons pass through Toronto International airport in a year. Nurses in the federal government's joint quarantine, immigration, and public service health unit, and in the Air Canada medical clinic, and St. John Ambulance staff discussed their work in providing health care for passengers, visitors, and workers at Canada's busiest airport.

Dorothy S. Starr, M.N.

Toronto International was Canada's busiest airport in 1970 and in 1971; although the 1972 figures aren't available yet, it will probably continue to rank number one in passenger traffic. More than 3,800,000 persons began or ended their air journey to points within Canada, or between Canada and the United States, in the Toronto International airport in 1971. In addition, there were thousands of travelers to destinations outside Canada and the USA.

Added to the passengers in the airport, there were visitors to see them off and welcome them back, the airline crews, and the personnel of the airport services. Some accidents and illnesses occurred among all these individuals.

Who looks after the passenger who has an asthma attack, the cook who cuts his finger, the visitor who slips on the escalator, the customs man with a headache, or the traffic manager with an upset stomach?

There are three groups of nursing personnel at the Toronto airport; they are behind the scene but readily accessible when health care is needed. Nurses and doctors from medical services branch of the department of national health and welfare are responsible for protecting Canadians from communicable diseases that might be imported.

Doctors and a nurse provide occupational health care for Air Canada employees at the airport, and a first aid post for passengers and visitors is staffed by St. John Ambulance personnel.

#### Federal health service

Six nurses staff the federal government health service at the airport; five of them cover the two shifts, 8 A.M. to 4 P.M., and 4 P.M. to midnight, and the sixth is the supervisor.

"We're here primarily for the quarantine and immigration operation.

The nurses' station is behind the desks where customs officers who are primary line inspectors for health, customs and immigration, give pas-

Ms. Starr is an assistant editor of The Canadian Nurse.



Ida M. Foote, medical services nurse, vaccinates Mary Rogers, a government employee.

sengers an initial inspection. The questions are short and standard: where are you coming from? how long did you stay? where do you live? While the inspector is looking at the passenger's passport, he is also looking at the passenger: checking for signs of illness.

The nurses look after the passengers who are referred from the primary line inspectors because they appear ill or cannot produce proper health certificates. Besides a small office, there is a room with two hospital beds and supplies for holding a passenger in quarantine, if necessary.

While Gladys Rundle, the supervisor, and I were talking, the office phone rang frequently. Lieselotte Wenck answered the phone with "Medical Services. May I help you?" One caller wanted to know what kind of injections she needed to go to Europe. Information calls of this kind are frequent.

Another call reported "the emergency has landed safely." Previously, the nurses had been notified that a pilot reported a plane was coming in for an emergency landing. The medical services' staff is always alerted in such cases.

Ms. Rundle told me that the nurses' major role in quarantine is the education of primary line inspectors. Courses include the history and current activities of the World Health Organization, and information about the four quarantinable diseases: smallpox, yellow fever, cholera, and plague. A projector and slides of individuals who appear ill as contrasted with those who look well, the symptoms of the four diseases, and the vaccination certificates are part of the teaching equipment.

All aircraft coming from outside Canada must be cleared by the medical services nursing staff before passengers are permitted to disembark. When an overseas or transborder flight arrives, the ground hostess or passenger agent who is responsible for the flight is the first person up the stairs when the aircraft door is opened; she or he inquires whether there is illness on the aircraft, and telephones the medical services nurse on duty.

The call is made on a special telephone, a "hotline" that commands instant attention from the nurses. Passengers are not allowed to leave the plane until the medical services nurse has been assured there is no illness on the aircraft.

Illness in this context is defined as anything except air sickness or an injury suffered before the passenger boarded the flight.

If there is illness, the nurse goes to the aircraft and establishes that the sick person is not bringing a quarantinable disease into Canada.

If the sick person has a rash and a temperature, the nurse may feel that he should be checked by a doctor. The sick passenger would be transfered to an isolation bed in the nursing unit, and the other passengers taken off the plane into a holding lounge.

An example of the rapid transmission of disease by air travelers was given by Ms. Rundle. In January 1972 Canadian regulations were changed so a traveler did not need a smallpox vaccination certificate unless he were coming from an infected area. Many persons went to Great Britain and to Europe without a vaccination certificate. In March, 1972, Yugoslavia reported 173 cases of smallpox, imported from Iran; the source of the two cases reported in Iran is unknown.\*

When the small pox outbreak occurred in Yugoslavia, everyone coming into Canada from Europe or the British Isles had to have a vaccination certificate. In the Toronto airport, medical services staff vaccinated more than 2,000 people, using the multiple pressure method. "We had quite a time," said Ms. Rundle. The nurses issued 11,050 health alert notices, warning incoming passengers that they might have been exposed to smallpox, telling them what symptoms to watch for, and advising them to contact their doctor if symptoms appeared.

Over 60 persons were placed on surveillance. This means the individual is asked to contact the medical officer of health (MOH) in the district to which he is going, and is told the length of

<sup>&</sup>quot;World Health Organization. "The Smallpox Situation." WHO Chronicle. 26:9: 397. September 1972.

time during which he should retain contact with the medical officer. The MOH might ask the traveler to come to his office or he might be in touch with him by telephone each day.

"We ask the passenger to report to the local MOH, and we send a eopy of the surveillance report to the MOH of the province to which the individual is going; the provincial MOH sends it immediately to the MOH in the district. Once we have made out the surveillance report and told the traveler what he is to do, it's up to the province."

Because of the possibility of sudden outbreaks of disease, the medical services nurses recommend that travelers keep their smallpox vaccination certificate up-to-date; it is valid for three years.

How are the nurses notified when an area becomes infected with a quarantinable disease? They receive the weekly World Health Organization epidemiology reports, a weekly report from DNHW, and one from the USA giving information for the western hemisphere. The nurses read these reports and keep lists of infected areas up-to-date for the primary inspectors. If there is an outbreak, most countries notify the WHO, which immediately disseminates the information to all other countries; DNHW sends a telex message to Canada's international ports.

A health alert notice is automatically given to any passenger coming from a cholera-infected area, since the incubation period for cholera is five days.

A traveler coming from a part of the world in which yellow fever is endemic is referred to the nurse. If he is remaining in Canada, no action is necessary because the mosquito that transmits the virus does not live in our climate. The southern United States, however, has an area in which the mosquito can survive. The nurse establishes where the passenger is going. If he is going to a receptive area, she telephones the US quarantine officials and informs the passenger that he may be placed in quarantine when he arrives.

When asked about the qualifications for the nursing duties of the medical services nursing staff, the nurses said that a registered nurse with experience would have to learn on-the-job. Openings for staff are scarce; the zone nursing director said of the Toronto airport staff: "They never leave." It's a fairly exciting environment, and many nurses are looking for an out-of-hospital job. Two of the six medical services nurses at the Toronto airport have been there since the unit opened 14 years ago; three nurses have been there for seven years, and the other for six.

A public service health unit is being opened for the approximately 900

public service employees who work at the airport: staff of immigration, eustoms, ministry of transport, RCMP, commissionaires, and airport postal service. The nurses will do occupational health procedures, including chronic and follow-up care. Four of the nurses have been oriented to occupational health already; they believe the preventive aspect of a public service health unit will be an addition to their present services.

When asked what is the most challenging part of their work, the nurses agreed that it is decision-making. They have to make many decisions, since the nurse is the primary health contact. There is a doctor on call at all times.

The most common health problems encountered in the medical services nurse's work are not dramatic. "Customs officers get headaches and immigration officers have upset stomachs. We don't know why it works out that



Three customs officers are given the latest word on disease problems likely to be brought into Canada, by Lisa Wenck, medical services nurse.

way but these seem to be occupational hazards."

One of the duties outlined for the DNHW nurses is to provide medical attention in an emergency or on a consultant basis for all airport visitors. passengers, and concessionaire employees. They carry on liaison with the St. John Ambulance first aid staff in a consultant capacity. In turn, the nurses may refer a passenger, who needs to lie down for a short time, to the St. John personnel.

First aid post

The first aid post in the main Toronto terminal is a small room on the arrivals level near gate 50. It is staffed with permanent, paid workers. The Toronto airport is the only St. John first aid post in Canada to maintain permanent staff; all others are manned by volunteers. By special arrangement the federal ministry of transport finances the first aid post and St. John Ambulance hires and trains the first-aiders. There is a supervisor, three full-time and one parttime worker.

The post is open seven days a week with two shifts covering the period 7:30 A.M. to 11:30 P.M. There are only a few people around after 11:30 P.M.; the DNHW nurses have one nurse on call for overseas flights coming in after midnight.

In April 1973, the new Terminal 2 building will be used for all Air Canada flights. St. John will move their main post into more adequate facilities there; Terminal 1, now the main terminal, will have a satellite first aid post.

The procedures done by the St. John Ambulance personnel at the airport are no different from those done at any other St. John post. The supervisor, Evelyn McIntyre, is a registered nursing assistant; she and all other St. John first-aiders take a multiple-choice



St. John worker, Evelyn de Bruin, bandages the wrist of Flavio Comun in the first aid room at Toronto international airport.

examination each year to make sure they keep up-to-date with changing techniques and "those little things you might forget," Ms. McIntyre said.

When an accident occurs, the first aid workers are usually notified by an RCMP officer or commissionaire; "they're patrolling all the time while we stay here in the first aid room.

"When they call us, they tell us what they think the problem is so we know whether to take oxygen with us. If the victim can't be moved, we get an ambulance, and if he can be moved, usually a wheelchair is sufficient to bring him to the first aid room."

In a typical 16-hour day the St. John staff treated three persons on the day shift, six on the evening shift. During the day a female employee had severe menstrual cramps; she rested a few minutes and was sent home. A restaurant employee cut his right hand; it was cleansed and dressed. A 79-year-old woman fell on the escalator. She was complaining of "tail bone pain" so her daughter took her to a Toronto hospital.

During the evening the first-aiders treated an employee with a heel rubbed sore by his shoe; bandaged a passenger's cut finger; administered toothache drops to a food service employee; and tended an RCMP constable with abrasions to his elbow.

That evening an airline employee got battery acid in his eyes; the firstaider bathed his eyes and advised him to see his doctor. A passenger who fell on the stairs at the "gate" bruised his shins; this individual was sent by car to a Toronto hospital.

The list of health problems in the terse records kept by the first aid workers includes cuts, burns, headache, nausea, diabetic shock, cardiac arrest, asphyxia, fainting, heart attack, insulin overdose, nervousness, twisted ankle, sprained knee, suspected miscarriage, drug reaction, and epileptic seizure.

"During the winter, around Christmas especially, we have a lot of patients who are emotionally upset. There's nothing we can do except talk to them."

An example of the need for emotional first aid: a St. John staff member was asked to help two neighbors who came to meet a woman, returning from England, whose husband had been found dead in their Toronto home that morning. The customs officers made a room available in which the neighbors could tell her the sad news. The first-aider helped them to see her through the first shock before she went home.

The commonest problem treated by the airport first-aiders is airsickness, for which they give Bisodol. They give aspirin only if the patient is sick and in the first aid room; if a passenger comes to their door asking for aspirin, they direct him politely to the airport drug store.

"We don't treat anyone who doesn't

want our help. Most people are eager for help if they've had an accident or feel sick. It's the individuals who don't have time to go to the doctor for an x-ray who are a worry. We make a report if they refuse to go."

Ms. McIntyre said they keep records of all accidents in the airport. Only if a report of an incident is requested by the airline or the ministry of transport do they make one. An accident that happens in the airport is the responsibility of the ministry of transport; outside the airport doors, on the field, the airline has the responsibility.

First-aiders at the Toronto International don't wear the St. John volunteers' uniform; they wear short white smocks over street clothes.

#### Air Canada

Rachel Gaw is the nurse in the Air Canada medical department at Toronto International airport; she has been with the clinic for 18 years, almost since its beginning. In the clinic, the doctors and Ms. Gaw deal mainly with medical examinations: initial employment physicals, routine compulsory medicals for air crew, voluntary routine medicals for ground crew, and backto-work examinations of employees who have been off the job because of illness or accident.

Pilots have a medical examination every six months, including vision tests, height, weight, urinalysis; every two years they have complete bloodwork, an audiogram, and an ECG. At age 40 and yearly thereafter, pilots have an exercise ECG.

Stewardesses and pursers have height and weight, and vision checked. Every two years they have a chest x-ray and complete bloodwork.

The most common ailments are colds and ENT problems. Colds are important for people flying because of the effect of varying air pressure on congested ear drums.

Ms. Gaw's work resembles that of a registered nurse working in the office of a doctor with an active general practice. She is on first name basis with most of the Air Canada employees. The majority of Air Canada patients are healthy individuals, so Ms. Gaw sees her job as an opportunity to practice preventive health care.

The Air Canada medical clinic nurse also has many inoculations to do, mostly smallpox, cholera and TABT (Typhoid, paratyphoid A and B, and tetanus). "We have people traveling all over the world, so I try to keep up-to-date on which shots are needed."

Ms. Gaw thinks the clinic campaign against smoking has been very successful. She says the men especially have stopped. No one in the clinic staff smokes now, and they have no ashtrays around. "It's fun to try to get our patients to stop," she said.

The clinic has two doctors fulltime, the nurse, and a secretary-receptionist who does the record keeping. The first clinic, staffed by one parttime doctor and Ms. Gaw, was in an air freight hanger.

She sounded wistful when she said, "We were on the edge of the runway and I saw all the aircraft, practically at my window. My desk faced out onto the field and the parking lot was on the other side of the office. Employees came by the window and waved; when I went to lunch I knew everyone. Then the airport grew and grew; now when someone comes in to the clinic, it's by appointment. The family atmosphere is gone."

One of the changes was the clinic's shift to a spacious suite in the airport administration building. The clinic is responsible for the care of 4,000 employees, who work in various areas



An ECG is part of the regular routine for Rachel Gaw and pilot Pardy.

of the airport. The Canadian National transportation system of which Air Canada is a part, provides care for Air Canada employees who work in downtown Toronto.

Ms. Gaw said, "We will probably move to Terminal 2, an all-Air Canada terminus; we'll be closer to the scene of our employees on the ramp. The DNHW staff are close to them in Terminal 1 so some of the employees walk in there, and St. John Ambulance looks after minor injuries. Any major injury has to be seen here for compensation purposes."

She taught herself to type when she first came to the Air Canada medical clinic; she did all the record keeping then. She has learned many other skills on-the-job, including how to do ECGs, blood counts, audiograms, diathermy, and the inoculations.

"Each day brings something or someone new and the work is never boring. Initially, each day was a challenge since I had to learn to earry out many tasks for which my nurses' training didn't prepare me."

Ms. Gaw has the same travel benefits as other Air Canada employees. She has done "quite a bit of traveling": Europe, Hawaii, California, the Caribbean islands, and the east and west coasts of Canada. "I used to go to Barbados nearly every year and then I decided I'd better start seeing other places too. Since then, I haven't backtracked on any regular basis."

If you need nursing help at the Toronto International airport, it's available; if you're looking for a nursing job there, none of the nurses seems inclined to leave.



Air Canada pilot, E.K. Pardy, concentrates on vision test given by Rachel Gaw, occupational health nurse with Air Canada.

# Trace elements in food

Many of the 92 chemical elements are essential to man. A few that may present problems related to human health form the basis of this article.

David J. Clegg, M. Sc., and Emil Sandi, Ph.D.

The ocean has been described as a dilute solution of practically everything. The same statement can also be made to describe living organisms, including man, although this has only become apparent in the recent past, thanks to the remarkable improvement in the sensitivity of analytical techniques. It is now believed that all elements are present in all living tissue, and many of them have been found.

There are, in total, 92 naturally occurring chemical elements. Of these, 11 (oxygen, hydrogen, earbon, nitrogen, sulphur, calcium, phosphorus, potassium, sodium, chlorine, and magnesium) account for more than 99 percent of the constituents of the human body. All 11 are, of course, essential for life.

In the case of the other elements, variously described as minor, micro, oligo, or trace elements, the questions arise: whether their presence in living organisms is indispensable or fortuitous, whether they are essential or toxic,

or whether they are apparently indifferent. The progress of seience makes any rigid classification futile.

Elements that would have been eonsidered toxic a few years ago are known today to be essential for many, or possibly for most, species. Such is the case of selenium, chromium, and molybdenum. Up to a definite level, an element may be required, may be essential, while somewhere above that level it becomes toxic. The margin between the two levels may be uncomfortably narrow.

Nutrient requirements of the human body are met by ingestion of food of animal, plant, and mineral origin. In the ease of the trace elements, however. additional sources must also be considered, since our environment can contribute considerable quantities of these. Thus, cigarette smoke, contaminated air and water, industrial and domestic pollution, and a variety of other environmental factors must all be taken into account.

It is the total exposure, related in turn to the amount retained in the body, that is the crucial factor to the individual. It is no consolation to be told that the total exposure to, let us say, lead via the food, is insufficient to result in toxic effects if the individual is also

The authors are in the Division of Toxicology of the Food Advisory Bureau of the Department of National Health and Welfare. Mr. Clegg is Head of the pesticides section, and Dr. Sandi is an expert with the food additives section.

subjected to a total inhalation exposure which, when combined with the dietary exposure, is sufficient to result in neurotoxicity.

This article will not permit even a brief review of all the elements in relation to human health. Instead some 11 elements which have presented, or seemed to present, problems related to human health will be briefly discussed. The elements will be considered in the order in which they appear in the periodic table.

#### Iron

Iron was the first trace element to be recognized as essential to man because of its role in forming hemoglobin fundamental to oxygen transport. More recently, even in those animal species that utilize copper (as chlorocruorin or hemocyanin) or oxides of vanadium in combination with protein (e.g., certain tunicata) for oxygen transport, iron has been shown to be necessary, since it is present in cytochromes (a hydrogen carrier) and a number of enzymes (catalase, peroxidase, and so on).

The adult human contains about 4 grams of iron, which is carefully conserved. Daily intake and excretion are in balance, at a level of about 1 mg/day. This balance is well controlled, since gut permeability to iron varies according to the body's need for iron.

Although iron is common in the environment, it is usually in a form not easily available to man. The major source of iron is in foodstuffs, especially animal products, such as liver and meat. Iron requirements vary considerably within a population. For example, menstruating or pregnant women, children, or blood donors, require more iron than a normal adult male. Iron deficiency is not uncommon. As a result, it has become necessary to "fortify" certain foods with iron (e.g., white bread, breakfast cereals,) to ensure that dietary intake is adequate for the whole population.

Toxicity of iron of food origin is unknown and is not likely to occur, but poisoning due to iron tablets through overdosage is quite dangerous and, unfortuantely, occurs frequently in children.

Hemochromatosis (iron storage disease) occurs infrequently in men and in women of postreproductive age. The basic cause of the disease is not due to increased iron intake, but to faulty iron metabolism, although there has been some speculation that a correlation exists between the disease, and iron fortification of foods. This is not proven, and at present it appears that iron fortification benefits clearly exceed any theoretical risks.

#### Cobalt

Cobalt requirement in man is small, the average adult human containing only about 10 mg. It is, however, an essential trace element for man, since it is a constituent of the B<sub>12</sub> vitamins.

The source of cobalt is food, where it is present in the form of B<sub>12</sub> vitamins in quantities generally less than 0.1 parts per million. Despite this low exposure level, B<sub>12</sub> deficiency has not been related to lack of it in the diet, but to the failure of its absorption via the gastrointestinal tract. This can easily be overcome by parenteral administration of vitamin B<sub>12</sub>.

Oral ingestion of inorganic cobalt has resulted in toxic manifestations in man. When the nutritional status is normal, excess cobalt stimulates hematopoiesis (excessive formation of blood cells) leading to a polycythemic condition. The mechanism is not fully understood, although cobalt is known to stimulate renal secretion of erythropoietin, which in turn causes erythropoesis and increased intestinal absorption of iron.

Prolonged exposure to cobalt under conditions of stress or disease (e.g., hemolytic anemia) has been reported to result in thyroid hypofunction accompanied by observable goiter. This condition is reversible once cobalt administration is stopped.

In Quebec in 1965-66, some 20 cases of human mortality occurred, which have since been attributed to inorganic cobalt toxicity. An inorganic cobalt compound was used in beer as a foam stabilizer. The additive was authorized on the assumption that beer intake would not exceed 6 bottles/day/ man. However, in the Quebec outbreak, intake of beer frequently exceeded 20 bottles/day/man. Even at this level, the amount of cobalt permitted in the beer did not prove toxic to individuals on a nutritionally adequate diet.

The Ouebec beer drinkers were not on such a diet, and the combination of a low protein diet, high alcohol intake, and high water intake resulted in the cobalt level inducing massive myocardial defects and subsequent death. Needless to say, cobalt is no longer permitted as an additive in beer.

#### Nickel

Nickel is found in the human body at a level of about 10mg./person. There are, however, wide fluctuations in the normal body burden of nickel.

To date, nickel is not believed to be an essential element in any animal species, and does not appear to have any biological role.

Nickel is present in vegetable foods at levels between 0.2 and 2.0 ppm; levels in foods of animal origin are considerably lower. The element is poorly absorbed by man and, since ingestion and excretion occur at similar rates, it is not accumulated with age, Ingestion of nickel naturally present in food does not correlate with any toxic phenomenon.

Occupational exposure to finely divided metallic nickel and to organic nickel compounds in certain industries

produces serious acute and chronic symptoms in man, including those of cancer.

Food contamination with nickel is rare. In stainless steel cooking utensils, the nickel, which may comprise as much as 25 percent of the stainless steel, is virtually insoluble and contributes only an insignificant amount to foods exposed to such utensils. Small residues, up to 2 ppm, can and do occur following the use of nickel catalysts in the manufacture of hydrogenated fats, such as margarine. There is no evidence to indicate that these small residues constitute any hazard to the consumer.

Copper

Copper is an essential trace element in animals, being a component of several specific enzymes and proteins. The normal body load in man is about 100 mg., with a daily requirement of 2-3 mg. This quantity is easily obtained from normal food, since most animal foods contain appreciable amounts of copper. Levels in plant foods are low (about 2 ppm) but dependent on the copper content of the soil on which they are grown, except in those cases where residues of copper-containing pesticides occur accidentally.

In man, the acceptable, or non-hazardous, upper intake limit for copper is about 25mg./day. This level is unlikely to be attained even when all routes of exposure are considered. An indirect effect of copper should be considered because vitamin C is rapidly destroyed in the presence of

copper ions.

A disease due to excessive copper stores in the body, Wilson's disease, is caused by faulty metabolism of the metal. There is no evidence that the disease can arise due to chronic ingestion of copper in amounts greater than normal.

Zinc is a natural constituent of foods and is an essential element for all living organisms. An adult human contains about 2.5 grams zinc, and a typical human diet supplies about 15 mg. zinc per day. This quantity is also considered optimal.

There appears to be a wide margin of safety between the levels of zinc in ordinary diets and the levels that could have harmful effects. Some shell-fish (e.g., oysters) contain up to 2,000 ppm zinc, and can be consumed without harmful effects.

As an environmental or food contaminant, zinc does not seem to pose any problems. It is possible, however, that future investigations may disclose hidden want of zinc in individuals who have one-sided food habits and prefer highly refined foods of vegetable origin. But from such diets other essential components may be missing besides zinc.

#### Arsenic

Although arsenic is frequently mentioned as the most typical and dangerous poison, its presence in foods presents fewer problems than one would expect. Arsenic is present in the human body in an amount of about 20 mg./person. Our foods contain generally less arsenic than 0.1 ppm, and its estimated daily intake is less than 2 mg.

Arsenic is not stored in the body, although some of it is permanently deposited in hair and nails.

A number of marine animals, such as crustacea (shrimp, crabs, lobsters), concentrate arsenic to an exceptional degree; they may contain 30 or more ppm of it. This arsenic is probably in organic form, which is rapidly eliminated by man. The same applies to those organic arsenicals that are used as growth promoters in animal feeds.

Except for surface contamination of food plants in the immediate vicinity of smelters, arsenic does not present any serious problem in our food supply.

#### Selenium

Selenium is present in the human body to the extent of up to 100 mg./ person. Its distribution is uneven, the

kidney and liver containing the highest amounts. Most of the selenium in living organisms is incorporated in amino acids, in positions otherwise occupied by sulphur. The turnover of selenium in the human and animal body is rapid; it is excreted in the urine.

The acute toxicity of selenium is higher than that of arsenic. There are somewhat contradictory reports on the relative toxicity of inorganic and organic selenium compounds; however, it has been proved that small amounts are required by animals, and probably also by man. In regions where the soil is rich in this element, a selenium excess disease is widespread in farm animals. A selenium deficiency disease is frequent in other regions where there is too little of the element available in the soil.

Our food supply contains generally less than 0.5 ppm selenium. This element does not seem to present any special problems for man, but it must be acknowledged that more research is needed to elucidate the metabolism and role of selenium in the human organism.

#### Cadmium

Cadmium is present in the human body to the extent of 30 mg./person, of which about 10 mg. is located in the kidney. The cadmium stores of man increase with age, the newborn child containing only minute amounts; the maximum tissue level is reached around the age of 40. This metal has no known metabolic function and is considered harmful. Its role is, however, not quite clear. In some animals, and perhaps also in man, it is bound to a special protein in the kidney and liver.

Foods, except kidney, contain generally less than 0.1 ppm cadmium. In oysters, the quantity of cadmium may reach peak values of 20-30 ppm—parallel with peak values of zinc. In general, the chemical behavior, and also occurrence of cadmium, is closely

linked with that of zinc.

Only about one percent of ingested

40 THE CANADIAN NURSE

cadmium is actually absorbed, but once absorbed it is firmly retained in the body. Its excretion is very slow. It is possible that the role of cadmium intake by inhalation (dust, cigarette smoke) is comparable to that of ingestion with food.

The cadmium content of Canadian foods is closely investigated and monitored. The daily intake by the average person is estimated to be around 0.1 mg./day. This value compares favorably with values estimated in other countries.

#### Tin

Tin is one of the very unevenly distributed elements. Its concentration in soils is generally low, and it is poorly absorbed by plants or animals. It has no known biological activity and is remarkably nontoxic if taken orally. An adult man contains about 10 mg of tin.

Foods contain generally less than one ppm tin, except canned food, which may contain much more. In a few foods (concentrated lime and lemon juice, canned asparagus, etc.) a soluble tin salt, stannous chloride, is used as a food additive.

The toxicity of inorganic tin salts is low; as much as 5,000 ppm was fed to animals for long periods without ill effects.

Animal experiments performed recently seem to indicate that tin may have some beneficial biological effect, and it may well be that it is essential to man and animals. Even if this proves to be true, our need for tin would be amply covered by the foods we eat.

#### Mercury

Mercury is also a widespread trace element, present in all living organisms. An adult man contains about 13 mg. mercury.

Small amounts of metallic or inorganic mercury do not seem to be dangerous to health. Most foods contain mercury in quantities of 0.005 — 0.100 ppm and this does not lead to any accumula-

tion of this element in the human body. Extensive data from industrial mercury poisoning cases show that inorganic mercury, though toxic, does not cause irreversible damage — except, naturally, in high doses, quite incomparable to the quantities ever present in foods.

Some organic mercury compounds, however, belong to the most dangerous and insidious poisons. These are the alkyl-mercury compounds such methylmercury and ethylmercury. These materials were formerly extensively used for the treatment of seed grains. In some developing countries such seed was consumed by humans out of ignorance. The consequence was always tragic — in several incidents hundreds of people died or became permanently injured. Plants grown from treated seed, however, do not contain appreciable amounts of mercury and are quite safe to eat.

The use of treated seed has had harmful consequences in this country also. Seed-eating animals, such as rodents and birds, were poisoned, as were their predators, or animals feeding on carcasses. The use of alkylmercurial seed dressings has been severely restricted in Canada, and their production and importation prohibited.

Mercurial seed dressing preparations are, however, not the only sources of these highly toxic alkylmercury compounds. It has been found that bacteria living in the mud of riverbeds and lakes can methylate otherwise harmless inorganic mercury deposits. The methylmercury thus formed is rapidly taken up by the plankton organisms and forwarded along the food chain to fish, and finally to the predators of fish, including man.

This food-chain effect is facilitated by two important factors. Methylmercury is a stable compound, and is not decomposed in biological conditions in any appreciable degree. The second factor is the permanence of this compound in the animal organism. In some fish it may take more than a year until half of the methylmercury present in its organism is eliminated. In man the biological half-life of methylmercury is about 70 days.

In two separate incidents in Japan, rivers were contaminated heavily with mercury by factories. Fish and shell-fish containing methylmercury were consumed by the population of fishing villages immediately downstream from the points of contamination. The result was widespread disease, many deaths, many permanently disabled victims, some of them congenitally poisoned. The symptoms, essentially irreversible, were paresthesia, progressive weakening of muscles, loss of coordination, constricted vision or blindness, deafness, and permanent mental retardation.

Intensive research efforts triggered by these tragic incidents unearthed some uncomfortable facts. It was found that some industries were polluting the rivers and lakes with relatively large amounts of mercury. The most important of these were paper-pulp manufacture and the chlor-alkali industry. It was found that fish in some of our rivers and lakes contained quantities of mercury dangerously close to the Japanese values involved in the mass poisonings mentioned. It was also found that practically all mercury in fish is in the methylmercury form.

Further investigations determined that some marine fish, like swordfish, tuna, and other predators also contain relatively high amounts of methylmercury. This is probably not related to any man-caused pollution, but due to the immense concentrating capacity of marine organisms.

Because of these observations, several administrative steps were taken to prevent damage to consumers. An upper limit of 0.5 ppm mercury is enforced in fish. This means that in several lakes and rivers fishing has been banned, and some marine fish are routinely analyzed, those exceeding the 0.5 ppm limit being excluded from commerce. The use of mercurial materials has been abandoned in the paperpulp industry, and the chlor-alkali

plants have introduced close controls to minimize any further escape of mercury to rivers or lakes. The existing mercury deposits in the rivers will, however, remain a problem for many years.

The recognition of the methylmercury menace has led to measures that should provide sufficient protection to the public. There remains, however, a remote risk to people with extravagant eating habits. Individuals consuming many pounds of fish per week should be cautioned to choose from different species, and not only from those containing relatively high levels of mercury, like tuna or swordfish.

#### Lead

The body of an adult contains, on the average, about 100 mg. of lead, but there are wide variations. Most of this lead is firmly deposited in the bones and is not considered harmful. But lead is definitely not an essential element and can be harmful to man and animals. Its effects range from hematological to central nervous symptoms, and it may produce serious, nonreversible brain damage, especially in children. Its acceptable, or rather unavoidable, intake can be tentatively placed at 5 micrograms/day/kg. body weight. This is equivalent to about 0.3 mg./day in adults.

ppm lead, and a typical Canadian diet would contribute only about 0.12 mg. lead per day. Unfortunately, other sources may also contribute to our lead intake. Atmospheric dust may contain relatively high amounts, especially in cities, because of the use of leaded gasoline in cars.

Another important potential source is pica in small children, which is a habit to eat or chew on objects other than food. Children living in old, dilapidated houses are the most exposed because of the presence of lead-containing paints on walls and furniture. Such paints are no longer used, but the problem will be with us for many years to come.

Another source of lead, occasionally leading to poisonings, is glazed pottery

from which excessive amounts of the metal can be leached by acid drinks, such as orange juice. The safety of glazed earthenware is now strictly controlled, but many households may still possess old and unsafe jugs and cups. The use of any suspect glazed earthenware for the storage of drinks should be discouraged.

Lead is therefore a potential and also actual harmful component of our man-made environment, but its critical source is not food, or not food alone.

#### Conclusion

In conclusion we wish to quote an age-old truth: dose alone makes poison (Paracelsus, 1530). All the elements, whether toxic, essential, or indifferent, are present in our organism and our food. Harmful effects are experienced only if their quantity is less than we need, or more than we tolerate. No element is all that dangerous, or all that useful. We have to live with every element, but we must try to do so wisely.

#### **Bibliography**

Bowen, H.J.M. Trace elements in biochemistry. New York, Academic Press, 1966.

Dinman, B.D. "Non-concept" of "nothreshold:" Chemicals in the environment. *Science* 175:4021:495-7, Feb. 4, 1972.

Frieden, E. The chemical elements of life. *Scientific Amer.* 227:1:52-60, Jul. 1972.

Jaulmes, P. and Hamelle, G. Présence et taux des oligo-éléments dans les aliments et les boissons de l'homme. *Ann. Nutr. Alim.* 25:6:B133-B203, 1971.

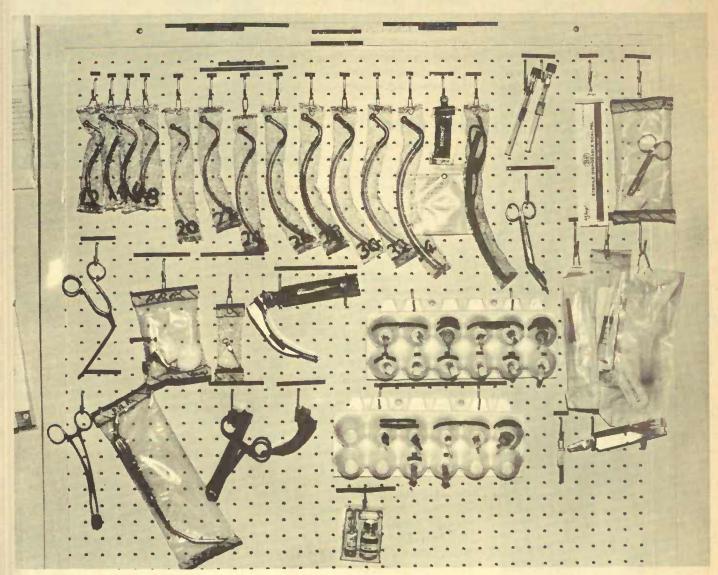
Mills, C.F., ed. Trace element metabolism in animals; proceedings of WAAP! IBP International Symposium, Aberdeen, Scotland, July 1969. Edinburgh, Livingstone, 1970.

Underwood, E.J. Trace elements in human and animal nutrition. 3cd. New York, Academic Press, 1971.

Symposium on mercury in man's environment, Feb. 1971, Ottawa. *Proceedings*, Ottawa, Royal Society of Canada, 1971.

Expert Group on Methyl Mercury in Fish. Report. Stockholm, Nordisk Hygienisk Tidskrift, 1971. (Supplement for Stockholm.)

# idea exchange



What we now use as a recovery room in our rather old 86-bed hospital was a nursery years ago. We had to make many alterations, and installed cupboards, wall suctions, swinging doors to the operating rooms, and piped-in oxygen.

We still have insufficient space, and have nowhere to put what is needed for an emergency, such as a cardiac arrest or a laryngospasm that is hard to get under control. That is why we came up with the arrangement illustrated.

As I am the only full-time nurse in the recovery room, we often have to depend on help by nurses who are not

#### Pegboard as space saver

#### **Marion Wendril**

too familiar with the various items needed for inserting an endotracheal tube. Therefore, we placed all such items on the pegboard and labeled them, together with endotracheal tubes of the sizes we use. We also added a tracheotomy needle and a cricothy-

The author is the recovery room nurse at Children's Hospital, Vancouver, B.C.

reotomy cannula, should it happen that an endotracheal tube cannot be replaced when an emergency airway is needed before a patient can be taken into the operating room for a tracheotomy.

We organized the board so that items needed for cardiac arrest are separated

from the endotracheal tubes.

The problem of how to put the small ampules of drugs and individual needles on the board was solved by using the bottom halves of styrofoam egg cartons. We just push an ampule or needle through the styrofoam and it stays there. With white egg cartons and red dynamo printing tape, the labeling shows up well.

# idea exchange

# **VON coordinates health care** for seniors



Barbara L. Prime

The Halifax branch of the Victorian Order of Nurses has become involved in a new and different type of health care program for the aged. Under an agreement with the Senior Citizens' Housing Corporation Limited, the VON has assumed responsibility for the coordination of health services at Northwood Manor, a complex housing about 500 senior citizens.

Northwood Manor provides three levels of accommodation and care under one roof: bachelor apartments for selfsufficient individuals, hotel-type rooms providing "sheltered care" for those who can no longer manage household responsibilities, and a 56-bed personal care unit for those who do not require active medical treatment, but need a health program just short of nursing care. The health staff is comprised of a registered nurse, a male aide, and six personal care workers. When nursing care is required by residents of the selfcontained apartments, it is provided through referral to the local VON branch.

The VON was accepted as the nursing agency to sponsor a general health care program at the manor because of its close association with various community resources and because it could guarantee a 24-hour back-up service by

This is the author's condensed report to the VON annual meeting in Hamilton, May, 1972. She is assigned to Northwood Manor in Halifax, Nova Scotia. the staff nurses of the Halifax branch.

My prime concern as the VON nurse assigned to the program is the coordination of total health service for the residents, focused on preventive health measures and rehabilitation. Major functions include a functional health assessment of all "sheltered care" applicants prior to admission; continual reevaluation of the health needs of all residents; assessment of the physical health of staff members at the time of employment; health counseling to both residents and staff; administrative supervision of the personal care unit; and the provision of first-aid, minor treatment procedures, and emergency nursing care as required.

Health counseling is one of my most time-consuming functions. Interpretation of diagnostic procedures, explanation of disease conditions and implementation of the doctor's orders, as well as sorting out drug medications and providing psychological support in times of stress and anxiety, are all important issues in a program that stresses health education.

Group activities have been organized. They include a weight watcher's club that has been most popular, particularly among the ladies. Group sessions with guest speakers and films have also been held for interested residents. Subjects have concerned diabetes, heart disease, and other common health problems, and the response has been excellent in all instances.

I am hopeful that a foot clinic serviced by a chiropodist and a physical fitness class conducted by a volunteer physiotherapist will become realities in the near future.

After less than a year at Northwood Manor, I am the first to admit how wrong I was to believe that the retirement years reflect only senility, disability, and boredom. Anyone who visits the complex will agree the nurse's role is anything but dul!!

I would like to make two recommendations regarding any health program for senior citizens undertaken in the future:

- The nurse functioning in this extended role must recognize both her capabilities and her limitations. Working with a great deal of independence, she must be aware of the danger of becoming involved in functions that are beyond her responsibility, for example, in the areas of diagnosis or treatment.
- The nurse, or some member of the health team, should be consulted regarding the architectural design of the areas of senior citizens' complexes that are to be used in providing a health care program. This would prevent additional construction costs once the building has been completed, and contribute to meeting more adequately the health needs of elderly people.

### dates

February 23-24, 1973

Canadian Rehabilitation Council for the Disabled, 10th annual meeting, Airport Hilton, Toronto. For further information, write to: CRCD, 2nd Floor, 242 St. George St., Toronto, Ontario.

#### March 14-17, 1973

Association for the Care of Children in Hospital, 8th annual conference, Stouffer Inn, Atlanta, Georgia. For further information, write to: Ms. K. Mason, Recreation Dept., Grady Memorial Hospital, Atlanta, Ga. 30303.

#### March 18-23, 1973

Association of Operating Room Nurses, 20th annual congress, McCormick Place, Chicago, Illinois, U.S.A.

April 12, 1973

Canadian Nurses' Association, annual meeting, Chateau Laurier Hotel, Ottawa, Ontario.

April 24-27, 1973

Canadian Public Health Association, 64th annual meeting, Queen Elizabeth Hotel, Montreal, Quebec. For further information, write to: CPHA, 1255 Yonge St., Toronto, Ontario.

April 25-26, 1973

Workshop on tuberculosis and respiratory disease for nurses working in public health, industry and hospital settings, sponsored by the New Brunswick Tuberculosis and Respiratory Disease Association, Chaleur Regional Hospital Annex Auditorium, Bathurst, N.B. No registration fee. For Further information, write to: A.H. Gardner, Executive Director, N.B. Tuberculosis and Respiratory Disease Association, P.O. Box 1345, Fredericton, N.B.

May 13-17, 1973

National OR Nurses' Convention, Skyline Hotel, Toronto, Ontario.

May 13-19, 1973

International Council of Nurses, 15th Quadrennial Congress, Mexico City.

May 14-15, 1973

Third annual conference, alumni committee, faculty of nursing, University of Western Ontario. Symposium, "Understanding and Helping the Family in Modern Society," to be led by Dr. Norman Bell. For further information, write to: Ms. Mary Gee, Publicity Chairman, 206 St. James St., London, Ontario N6A 1W8.

May 23-25, 1973

Registered Nurses' Association of British Columbia, annual meeting, Bayshore Inn, Vancouver, B.C. Conference theme: "Changing Health Service."

May 29-31, 1973

New Brunswick Association of Registered Nurses, annual meeting, Hotel Beausejour, Moncton, N.B.

June 3-9, 1973

Collective bargaining summer school, Glendale College, York University, Toronto. Registration fee, including room and board: \$75. For further information, write to: George Richards, Employment Relations Officer, Registered Nurses' Association of Ontario, 33 Price St., Toronto, Ontario.

June 10-13, 1973

Workshop on Test Construction for Teachers in Nursing Education, sponsored by The University of Western Ontario, London. Instructor: Professor Vivian Wood. Tuition fee, including accommodation and meals: \$125. For further information, write to: Summer School and Extension Dept., U. of Western Ontario, London 72, Ont.

June 13-15, 1973

Registered Nurses' Association of Nova Scotia, annual meeting, Halifax, Nova Scotia.

June 29-July 1, 1973

Homecoming Weekend, Nova Scotia Hospital Alumni Association. For further information, write to: Ms. Brenda Sinclair, 138 Pleasant Street, Dartmouth, Nova Scotia.



# in a capsule

If you drive a car

Knowing what to do in cold weather conditions makes for safe driving. The Canada Safety Council gives the following advice to car owners.

• Have your tires, brakes, cooling system, exhaust system, battery, windshield washer and wipers checked and repaired, if necessary, before the snow flies (better late than never).

• Use a light touch on the gas when starting in snow or on icy surfaces. Too much power will only spin the wheels and make matters worse. Try starting in second gear for added traction.

• If you get stuck, try turning the wheels from side to side a few times to push the snow out of the way, then steer straight ahead and ease forward slowly. If you are still stuck, shovel away as much snow as possible from around the tires. Spread a little rocksalt, sand, or ashes under the tires, and, if you have pieces of carpeting, place them in front of the rear wheels. Now gently rock the car back and forth, shifting from forward to reverse. If

your car has automatic transmission, check the owner's manual for the proper procedure for rocking. With each rock, you should gain a little ground. However, tire chains are still the best answer for getting out of such situations.

• When driving on ice or snow, remember it takes a much greater distance to bring your car to a halt than it does on dry pavement. Always leave more room between you and other drivers. Reducing your speed not only increases your chances of stopping in time, but also helps reduce the possibility of skids.

• Don't slam on the brakes. You'll lock the wheels, which could result in an uncontrolled skid. Pump your brakes gently to maintain steering control.

• If you start to skid, don't panic. Keep a firm grip on the steering wheel, take your foot off the accelerator, and steer in the direction the rear of the vehicle is skidding. Be careful you don't overcompensate. When you feel the car regaining traction, straighten your wheels and be prepared to handle a skid in the opposite direction.

• Use your low beams when you drive through fog or a heavy snowfall. High beams reflect light off the fog or falling snow and can be blinding for a driver. If the visibility gets too bad, don't be a hero. Pull well off the road with your emergency flashers on and wait until the fog or snowfall lets up.

Preparing for ICN

For those who have been chosen as representatives to the ICN Congress in Mexico City in May, the following suggestions in the RCN Nursing Standard in the United Kingdom (November/December 1972) should help you get ready to participate professionally in the week-long meeting.

• Be fully informed on all aspects of nursing, including achievements of your national nursing association since the last ICN congress in 1969 and international trends in nursing.

• Know about developments in your

own nursing specialty.

• Be interested in international affairs generally.

• Know the background of the ICN and other international organizations through which nursing interests are represented, such as WHO, ILO and the Red Cross.

• As well as being informed, be a reasonably good speaker so you can take part in plenary sessions:

• Be able to write a report of the congress proceedings when you return home. Such a report should be suitable for publication.

• A working knowledge of French or Spanish will be useful, particularly during any professional visits or postcongress tours.

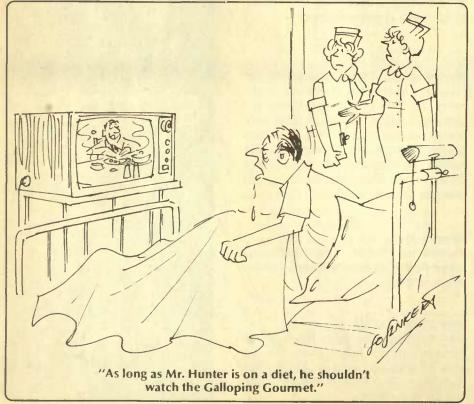
This is the advice of Tatiana Vergebovsky, international secretary of the Royal College of Nursing in the U.K.

Please post our "leaklets"

We recently received a press release inviting us to attend a talk on the changing role of the nurse. The letter also asked us to post the enclosed "leaklets" announcing the event.

After reading the letter, one staff member suggested it would be rather difficult to do this. Another staff member asked: "Who's going from here?"

Yes, typos can be fun.



### names



Sister Therese Carignan is the new executive director of the Manitoba Association of Registered Nurses. She succeeds Bente Cunnings, who was executive director from 1969 to 1972.

Sister Carignan (R.N., St. Paul's H., Vancouver, B.C.; B.S.N., Seattle U., Washington) was appointed an instructor at the University of British Columbia School of Nursing in 1969. Other nursing positions she has held include director of the Training Centre at Lake of the Woods District Hospital, Kenora, Ontario; coordinator of inservice education at St. Mary's Hospital, New Westminster, British Columbia; and supervisor in hospitals in British Columbia, Alberta, and Ontario.

Daisy Caroline Bridges (CBE, RRC, SRN, SCM, FRSH) died in London November 29, 1972, following a three-month illness. She was general secretary of the International Council of Nurses from 1948 to 1961.

Announcing her death to the members of the professional services committee at ICN headquarters, ICN president Margrethe Kruse said: "Daisy Bridges was tireless in her devotion to nurses, nursing, and ICN. She will be remembered with deep affection by all the nurses around the world who knew her: ICN will forever honour her as the person who rebuilt our international federation following World War II and who later wrote the history of ICN's first 65 years."

Daisy Bridges qualified as a nurse at the Nightingale School, St. Thomas's Hospital, London. During the second world war, she served in France, Egypt, and India with Queen Alexandra's military nursing service. After the war she was appointed a member of the ministry of health working party on recruitment and training of nurses in the United Kingdom. She was also a member of the first and second expert committees on nursing of the World Health Organization.

For her service in the Middle East during the war, she was awarded the Royal Red Cross. She later received the CBE (Commander of the British CNA Executive Director Promoted To Commander Sister



Dr. Helen K. Mussallem, *right*, was promoted to Commander Sister of the Order of St. John at an investiture at Government House November 9, 1972. With the Canadian Nurses' Association's executive director is Yolande Fournier, director of the school of nursing at the University of Ottawa, who was made a Serving Sister of the Order of St. John. His Excelleney the Rt. Hon. Roland Michener, Prior of the Order of St. John in Canada, awarded the insignia shortly before the photograph was taken at Government House.

Empire), the Coronation Medal, and the Florence Nightingale Medal of the International Red Cross.

Huguette Labelle (R.N., B.Sc.N.Ed., B.Ed., M.Ed., U of Ottawa) has been appointed principal nursing officer, department of national health and welfare. She began her work as the federal government's chief nurse on February 1, 1973.

3

Ms. Labelle is president-elect of the Canadian Nurses' Association. She has been director of the Vanier School of Nursing, Ottawa, since its beginning in 1967. Prior to that, she worked

vith the Ottawa General Hospital

school of nursing as clinical teacher, clinical coordinator, and associate director of nursing education.

Ms. Labelle is a director of the Ottawa-Carleton United Appeal, a member of the Ottawa Council on education of the health disciplines, and chairman of the OCEHD's committee on nursing services and education.

She was chairman of the CNA special committee on French-language textbooks, and is a member of the board of the CNA Testing Service.

Ms. Labelle is married and has two children, Chantal, 10, and Pierre, 9.

Judy Hill, a 27-year-old nurse from England who was working for the department of health and welfare's northern health services, died in November 1972 in the wreckage of a chartered aircraft. The small Beechcraft 18 plane

#### names

was carrying two patients on a mercy flight from Cambridge Bay to Yellowknife, Northwest Territories.

National Health and Welfare Minister Marc Lalonde paid tribute to the nurse's selfless devotion to duty "Nurses like Miss Hill in their isolated arctic nursing stations are the backbone of the Northern Health Services. They are expected to deliver babies, sew up minor wounds, sometimes pull teeth..., perform minor laboratory tests, know how to take x-rays and, most important, know when to refer patients to doctors..."

Born in Wolverhampton, England, Judy Hill took her nursing training at St. Bartholomew's Hospital in London and did midwifery at Southmeade Hospital in Bristol. After working as a staff nurse in England, she went to Nova Scotia in 1969, where she worked at Fisherman's Memorial Hospital in Lunenburg. From there she went to the Queen Elizabeth Hospital in Montreal and to Chateau Lake Louise Hotel in Alberta. In November 1971, she assumed the position of a northern nurse stationed at Spence Bay, Northwest Territories.

The Canadian Nurses' Association sent a telegram to Mr. and Mrs. L.G. Hill in Kingsbridge, Devonshire, England, expressing sympathy.



M. Josephine Flaherty is the new dean of the faculty of nursing at the University of Western Ontario in London, effective July 1, 1973. In 1972-73, the faculty had an enrollment of 310

undergraduate and graduate students

and a faculty of 30.

Dr. Flaherty (B.Sc.N., B.A., M.A., Ph.D., U. of Toronto) has been assistant professor in the department of adult education at the Ontario Institute for Studies in Education (OISE) in Toronto since 1967. Previously she was a graduate assistant in the department of measurement and evaluation at OISE and a lecturer in statistics and research design at the Nova Scotia Summer School at Dalhousie University, Halifax.

She has also been a consultant to a number of schools of nursing in Canada, has worked in general duty and public health nursing, and has taught in university and diploma programs. From 1956 to 1958, Dr. Flaherty was the charge nurse at the Red Cross outpost in Matachewan, Ontario.

Dr. Flaherty is president of the Registered Nurses' Association of Ontario, a member of the RNAO committee on research in nursing, a member of the Canadian Nurses' Association special committee on research, and a member of the board of directors of the Canadian Nurses' Foundation. She has published widely in Canadian journals.

As dean of the faculty of nursing at UWO, Dr. Flaherty succeeds R. Catherine Aiken who has been dean for 13 years. She is taking a study leave and will return to the university as a professor. Dean Aiken joined the faculty in 1958. For the past six years, she was a member of the Ontario Council of Health — the senior advisory committee to the Ontario government through the minister of health.



E. Margaret Bentley (R.N., Royal Victoria H., Montreal; dipl. PHN, Dalhousie U., Halifax) was installed as president of the Canadian Public Health Association, Nova Scotia branch,

at the 22nd annual conference in Truro, Nova Scotia, in October 1972.

Since 1968, Ms. Bentley has been employment relations officer for the Registered Nurses' Association of Nova Scotia. Before this she worked in the Nova Scotia department of public health.



Monica D. Angus, past president of the Registered Nurses' Association of British Columbia, has been awarded the 1972 Alice E. Wilson Award by the Canadian Federation of Uni-

versity Women and has been elected to the University of British Columbia Senate for a three-year term.

Ms. Angus (R.N., St. Paul's H., Vancouver; B.S.N. and M.A., U. of British Columbia), a graduate student in psychology at Simon Fraser University in British Columbia, won the \$500 award for university study. The award is named after Dr. Alice Wilson, who was a distinguished Canadian scholar and geologist.

The British Columbia Status of Women Group first approached Ms. Angus to run for the UBC Senate. Her nomination was submitted, however,

by men and women from her 1970 adult education class at the University of British Columbia. She has been appointed by the university president to serve on the new programs committee.

Sister Barbara McKinnon (R.N., St. Joseph's H., North Bay, Ont.; B.Sc.N., Ottawa U.; M.Sc.N., The University of Western Ontario, London) has been appointed director of nursing service, St. Joseph's General Hospital, Thunder Bay, Ontario.



Sister McKinnon has held a number of varied positions in North Bay, Sudbury, and Thunder Bay, Ontario. These included director, nursing service and education; supervisor; teacher; and

staff nurse. For the past six years, she has been a member of the faculty of Lakehead University School of Nursing

in Thunder Bay.

As an active member of the Registered Nurses' Association of Ontario, Sister McKinnon has worked on various committees at the local and provincial level. She is currently a member of the provincial standing committee of nursing administrators, an elected representative to the Council of the College of Nurses of Ontario, and has been a member of the Council for the past three years. She was recently appointed to the Catholic Hospital Conference of Ontario Nursing Committee.

Evelyn C. Aquino (R.N., St. Joseph's H., Sudbury, Ont.; dipl. PHN, U. of Ottawa; B.A., U. of Windsor, Windsor, Ont.; M.Sc.N., U. of Western Ontario, London) has been appointed assistant professor of community health nursing at the University of Windsor in Windsor, Ontario.



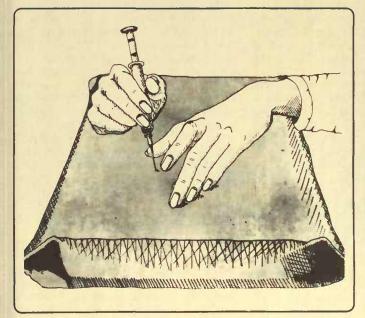
Ms. Aquino has worked at St. Joseph's Hospital in Sudbury; with the Sudbury and District Health Unit as a public health nurse; and has taught nursing at Kingston General Hospital and at

Hotel Dieu Hospital in Kingston, On-

Active in professional and community affairs, Ms. Aquino is working with the nursing executive committee, nursing section, Ontario Public Health Association.

In 1972, she received the University of Western Ontario intramural scholarship.

# new products





ECG Sensor

Injection Training Aid

Injection training aid

The "injecta-pad" is an injection training aid that duplicates the feel of body tissues. Tissue displacement, needle insertion, and aspiration tension all approximate a live injection.

Students learning injection techniques can perfect skills prior to clinical assignment. This aid is also of special value to hospitals for teaching injection technique to patients, for example, the patient with diabetes.

This polyethylene-covered pad measures 10 x 10 x 2 inches and weighs 9 lbs. For further information, write: Wallcur Enterprises, 700 Island View Drive, Seal Beach, California 90740, U.S.A.

#### **New ECG sensor**

QRSstat, a hand-held, battery-operated instant ECG sensor, has been introduced by Instromedix medical instrument manufacturer.

The QRSstat can be used as a selfcontained ECG, with the principal ECG displayed on a small meter, or it can be used as a probe and preamplifier for a standard electrocardiograph or scope monitor. It enables the operator to identify, within a few seconds, the type of cardiac arrest.

To use the QRSstat, the operator

places it on the patient's chest; no electrode jelly, limb lead, or skin preparation is necessary. The type of cardiac arrest may be determined immediately by reading the meter, or by telephone transmission. For immediate diagnosis, rhythm strips may be taken in the home, factory, or office.

For more information, write to Instromedix, Inc., 2330 N.W. Flanders, Portland, Ore. 97210, U.S.A.

Intravenous support equipment

Castle Company, a division of Sybron Corporation, has introduced the 5700 Series Intravenous Support Equipment for the efficient administration of parenteral solutions in operating rooms and patient care areas.

Castle overhead tracks for intravenous feeding offer complete mobility and accessibility. This feeding support fully adjustable to multiple highor low-feeding positions. It features a push button release at a convenient, easy-to-reach level under the lower of the multibottle holders; height and lateral adjustment control is thus always within fingertip reach. The eight-hook unit, which is completely off the floor and out of the way, locks securely at the required hydrostatic flow point.

able, or the unit can be mounted on a straight ceiling track. Form 5731, available on request, provides space for a layout diagram sketch and other pertinent information. Write to Castle Co., 1777 E. Henrietta Rd., Rochester, N.Y. 14623, U.S.A.

#### Literature available

Illustrated information summaries about seven Silastic orthopedic implants (Swanson Design) are given in a new letterhead-size file folder (Form 51-177) available on request from Dow Corning Silicones Inter-America Ltd., I Tippet Road, Downsview, Ontario. The folder is designed with a pocket to contain the professional literature, also available upon request, on each of the implants.

The implants, made of Dow Corning silicone elastomer Silastic, are flexible, softer than bone, durable, and nonreactive with bone, tissue, and fluids. The Silastic finger joint implant is the best known and most widely used. There are six other implants. All perform the same function, acting as dynamic spacers to preserve normal joint space relationships during formation of the supportive capsule in appropriate

"U"-shaped or oval tracks are availjoint arthroplasty cases.

# research abstracts

The following are abstracts of studies selected from the Canadian Nurses' Association Repository Collection of Nursing Studies. Abstract manuscripts are prepared by the authors.

Simms, Ada Elizabeth. Nursing research in Alberta: a beginning descriptive study. Edmonton, Alta., 1972. Major paper (M.H.S.A.) U. of Alberta.

The primary research problems undertaken in this study were: 1. describing nursing research in Alberta in terms of what has been done, where, and by whom; and 2. collecting basic information relating to the planning, organization, and coordination of nursing research in that province. The purpose of the study was to provide baseline data for facilitating the rationalization of future nursing research in Alberta.

Three techniques of data collection were employed: an analysis of the literature on the organization of research in general and nursing research in Canada specifically; a questionnaire; and the Strategic Informant Technique, used primarily to widen the investigator's perspective on the research problems

In this project, the emphasis on nursing research was basically of a non-evaluative, categorical nature and did not constitute a qualitative assessment of the methodology of research projects. No attempt was made to ascertain the reliability and validity of the reported data.

A total of 332, two-part questionnaires were sent to Alberta organizations whose central mission is that of health care, education of health personnel, and/or health research. Part I of the questionnaire related to nursing research conducted in Alberta; Part Il consisted of questions on the intraorganizational structural mechanisms for facilitating nursing research and on perceived areas of research priority. Twenty interviews were requested from Strategic Informants; 18 of these were completed.

A request was made for return of the questionnaire whether or not there was research to report; 206 of the 332 questionnaires were returned. Seventyseven studies were reported through the questionnaire returns, and the investigator located 14 additional studies in which the central focus was nursing, making a total of 91 studies. Sixtyninc of these were completed research projects, the earliest dated 1949, with

22 currently in progress.

Most completed research has been in nursing administration, less in nursing education, and still less in nursing practice. The latter is considered by respondents to merit current priority. There seems to be a definitive trend toward a quantitative increase in nursing research since 1969. Proportionately, universities have generated more nursing research than other types of organizations. Multi-disciplinary nursing research, and funding of nursing research, as yet appears to be minimal. A paucity of full-time nursing research positions, committees, and consultative services exists. The Strategic Informant interviews indicated an urgent need, both quantitatively and qualitatively, for improved nursing research manpower.

Recommendations based on this investigation include: 1. a systematic annual inventory and qualitative assessment of completed nursing research; 2. a nursing research manpower study; 3. an analysis of the types and amounts of nursing research educational programs needed; and 4. systematic budgetary provision by university schools of nursing to enable selected faculty to carry out substantial research activities, including involvement in consultation and project direction in cooperation with other agencies and individual nurses.

The investigator also recommends the establishment of an institute for health services research in Alberta that would, among other functions, give impetus and expert assistance to persons and agencies doing nursing research.

Parker, Nora 1. The effects of error modeling on the learning of a complex procedure in nursing. Toronto, Ontario. 1972. Thesis (Ph.D.) U. of Toronto.

This study was designed to investigate the effect of error modeling on the learning of a unit of a complex procedure in nursing. The investigation was based on the assumption that information about errors acquired during the cognitive phase of skill learning would assist the learner to choose the correct alternative in performing the skill. Demonstration of a correct performance of the total procedure was followed by error modeling in a unit of the procedure for the experimental subjects, and positive exemplary modeling for the control subjects.

A two factor repeated-measures design, which would test a treatment effect, trials effect, and a treatment X trials interaction, was set up for the study. Seventy-one second-year nursing students were randomly assigned to three groups: two experimental groups

and one control group.

The modeling tapes produced for the study consisted of one video tape with positive exemplary modeling only, and two other tapes, each of which contained two errors in surgical asepsis. It had previously been determined by the experimenter that the modeled errors occurred frequently, both in the preparation for and application of a

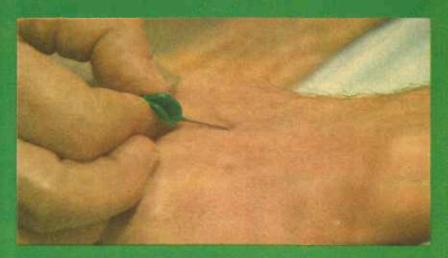
surgical dressing.

After viewing the modeling tapes, all subjects had two practice trials on the preparation of a surgical dressing tray. Six observers participated in this stage of the research, individually observing the performance of each subject and recording each occurrence of the four modeled errors. No instruction or correction was given by the observers. The error count constituted the data for this phase of the investigation. There were no significant differences among groups in the number of errors or in the proportion of subjects who met criteria of adequate performance with respect to each of the separate

A second question examined in the study concerned the transferability of information regarding errors to a task involving discrimination of errors in the performance of another person. A fourth video tape showing the complete procedure and containing 14 errors was used in the discrimination test. This video tape was shown to all subjects at the same time and under the same conditions. Subjects were asked to assess the performance of the nurse with respect to surgical technique as well as other aspects, but the instructions did not mention errors. Data

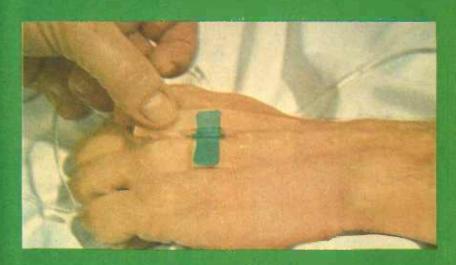
(Continued on page 52)

# We've put a handle on VENIPUNCTURE...



Just hold the Butterfly Infusion Set for venipuncture. The wings fold upward easily to serve as a needle sure grip: all the "handle" you need for accurate manipulation and easy

# ...and an anchor on SECURITY



### Start your next I.V. procedure with a Butterfly Infusion Set

Ultrasharp needle has a short-bevel point for easy entry thinwall construction that allows for increased flow without increasing outside needle diameter. Slim, hub-less design and soft, flexible tubing for easier handling. There's a size for almost every infusion need. Ask your Abbott Representative to show you our entire collection.

Simply release the Butterfly wings after venipuncture. They fold back and lie flat against the patient's skin. surface. Just tape them down and

Large-bore Butterfly-14 and 16 for surgery or hemodialysis

Medium gange Butterfly-19 and Butterfly-21 for general-purpose infusions

Special Butterfly-19, INT and Butterfly-21, INT with rescal cap for intermittent LV, therapy

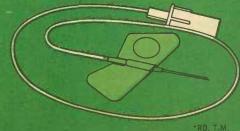
Small-gauge Butterfly 23 and Butterfly-25 for pediatric geriatric use

Short-cannula Butterfly Short-25 for scalp vein infusions

# **BUTTERFLY** INFUSION SET



The Venipuncture Specialists --Quality I.V. equipment to meet every need



#### research abstracts

(Continued from page 50)

consisted of the number of errors in surgical asepsis noted by each subject. Simple analyses of variance along with Duncan's Multiple Range test were used to assess differences among groups.

The principal findings of the study were: 1. On the practice trials there

were no significant differences among groups as a result of the modeling treatments. 2. No negative effect of the error modeling was observed. 3. In a discrimination test, a significantly larger number of the total errors shown on the video tape was discriminated by the subjects in the two experimental groups than by the control subjects. The experimental subjects also detected more of the errors that had been modeled for them.

The results were interpreted as providing some support for the view

that information about errors can increase the learner's ability to discriminate the critical requirements in the performance of a skill. Since the modeling of errors did not appear to assist the learner in actual performance of the procedure, a distinction between skill in discrimination and performance skill is suggested. This distinction implies that the person may be unable to perform a task correctly although he has discriminated what is necessary.

Rivett, Roberta Edith. A study to develop instruments to evaluate the effectiveness of a post-diploma program in nursing. London, Ont. 1972. Thesis (M.Sc.N.) U. of Western Ontario.

In response to the need of a community college for means to evaluate the effectiveness of a series of postdiploma courses in intensive care nursing, a methodological study was carried out to develop evaluative instruments.

Three instruments were developed:

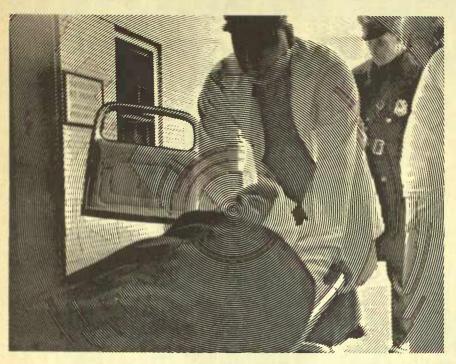
1. A Personal Data Inventory to collect data on the characteristics of study respondents, who are: (a) students enrolled in courses of the program; (b) the immediate superiors of these students in the home hospitals, where applicable; and (c) the directors of nursing of the home hospitals, where applicable.

2. An Intensive Care Nursing Competency Model, with a rating scale, and listing skills expected of an intensive care nurse. Respondents to this instrument, the students and their immediate superiors, are able to rate students' skills at the beginning of the course and at the end of the course (students only) and three months postcourse as a follow-up measure. The Competency Model is designed so that analysis of data identifies changes in skill as perceived by the student and her immediate superior, one explanation for which may be the student's participation in the program.

3. An Expectations Rank-Order Scale, from statements of expectations of the course derived from interviews with study respondents. Respondents rank in order groups of expectations at the beginning of a course of the program, and three months following the end of a course as a follow-up measure, to identify the extent of realization of expectations.

The study described in detail the methodology of development of these instruments, their testing with the participants from the first four courses of the intensive care nursing program, and the methods identified for analysis of resulting data.

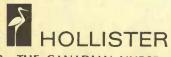
# EMERGENCY!



# make no mistake about it!

Another patient is rushed into the emergency room, but even before diagnosis and treatment he must be identified or assigned a number. The reason is obvious and compelling: the right treatment must be given to the right patient...even if he is unconscious, confused, or unable to speak.

Hospitals throughout the United States are solving this real problem with a proven method of identification: Emergency Room Ident-A-Band by Hollister. Takes only seconds to apply to the wrist of each emergency patient. Hospital number and name (if known) are hand lettered right on the band. No insert card is required. Its distinctive color singles out the emergency patient from all others.



LTD., 332 CONSUMERS ROAD, WILLOWDALE, ONTARIO

# books

Nursing Administration in the Hospital Health Care System by Edythe L. Alexander. 317 pages. Saint Louis,

Mosby, 1972.

Reviewed by Margaret A. Beswetherick, Assistant Professor, School of Nursing, The University of Alberta, Edmonton, Alberta.

The format of this text is such that references and cross-references are easily located with the assistance of the comprehensive index at the back of the book. The content is focused toward those who find themselves in leadership positions — team leaders to nurse administrators. The author states: "The goal is to assist in the implementation of a positive dynamic management framework . . . . "

The first three chapters provide a comprehensive, historical overview of the development of nursing service within the American setting. This material is of historical significance but is of limited value when it comes to understanding the development of nurs-

ing service in Canada.

The focus of chapters 4, 5, and 6 is on studies, reports, and research that have influenced the development of nursing services and the formulation of standards of care. Again, the emphasis is on developments within the USA. Though development within Canada seems to parallel events in the United States, there are significant differences that need to be understood. For this reason, the first 86 pages would require extensive interpretation should this book be adopted as a student text.

Principles of management, theories of organization, and work study methods are briefly outlined; the systems concept is presented in greater detail.

Another chapter deals with philosophies, goals and objectives; policy formation; organizational structures and communication; and management by objectives.

A variety of management tools are discussed or briefly presented; these include organizational charts, manuals, accreditation standards, reports, conferences, committees, and auditing check lists.

Management of nursing manpower in the provision of care is the topic of chapter 12. Budgeting methods, evaluation, and control of resources are thoroughly interpreted.

This book deserves a place on the book shelf of anyone concerned with nursing service administration.

Quick Medical Terminology by Genevieve Love Smith and Phyllis E. Davis. 248 pages. New York, Wiley,

Reviewed by Patricia Ellis, lecturer, McMaster University, School of Nursing, Hamilton, Ontario.

In keeping with today's emphasis on independent study, the authors have prepared a self-teaching aid to increase the vocabulary of anyone requiring knowledge of medical terminology.

Objectives of the self-study program are clearly stated in behavioral terms and stem from the central objective that the reader will learn and then apply the word-building system presented in Unit 1. The word-building system teaches the reader to combine Greek and Latin prefixes, suffixes, word roots, and combining forms into compound words. Once the system is mastered, the reader should be able to recognize and understand word parts, build material terms given the meaning of a word, and apply the system to increase medical vocabulary.

Each of the remaining nine units begins with a clear and concise statement of what the reader will learn followed by a list of word parts and their meanings presented in that unit. Then, a series of programmed exercises are given for the reader to complete at his own rate. There is immediate feedback with the correct response appearing to the left of the question. At the end of each unit, there is a test to determine progress. The book concludes with review material, two final self-tests, and lists of both old and new word parts.

Many of the exercises presented utilize rote learning and repetition. There is an attempt, however, to use problem-solving by asking the reader to analyse and synthesize new words based on previous knowledge.

The book is helpful with more than medical terminology. Words are placed in groups to show relationships rather than just listing isolated terms, and proper usage of the words in the medical field is presented. Besides words and definitions, the exercises

often include basic medical facts related to the terms, which help to increase the reader's understanding of medicine. Finally, through simple but clearly labelled illustrations, the reader gains a beginning knowledge of anatomy.

This book would be useful for anyone new to the medical field, such as beginning nursing students. It could, however, benefit those already working in the medical field by providing a review plus a systematic method for increasing knowledge of medical terminology.

The Newborn and the Nurse (Saunders

Monographs in Clinical Nursing — 3) by Mary Lou Moore. 290 pages. Toronto, Saunders, 1972.

Reviewed by Carmen Cummings, Etobicoke General Hospital, Rexdale, Ontario.

The preface states that caring for the newborn "constitutes a very special kind of nursing" and that the nurse must "appreciate his special characteristics and needs and help his parents to understand them too." This purpose is clearly met throughout the book. The author includes the role of the parent as she discusses infant care.

The first chapter, dealing with the fetus in utero, covers conception, gestational age, and genetics, including an explicitly simple explanation of the DNA molecule. A great deal of attention is given to the effects of the fetal environment including the environment provided through drug addiction of the mother. The section is well organized and covers all the latest procedures and techniques such as amniography, amniocentesis, steroids during pregnancy, blood group incompatibilities, and monitoring of the fetus.

Other chapters discuss the fetus during labor, transition to extrauterine life, the characteristics and needs of the healthy newborn, the newborn with problems, nutritional needs of the newborn, the influence of culture on pregnancy and on our interaction with the parents.

The last chapter looks at infant mortality rates compared in various

countries.

The book is clearly written, well organized and explicit. The author uses research material, illustrations,



#### Tucks\*

offer prompt, temporary relief from the discomforts of itching, burning and irritation associated with hemorrhoids, post-operative anorectal surgery wounds and episiotomies. Used as a compress, they relieve itching and edema with a cooling, mildly astringent action. As an after stool wipe, Tucks gently and thoroughly cleanse while soothing tender, traumatized tissues. Moist, soothing Tucks are soft disposable flannel pads saturated with Witch Hazel (hamamelis water) 50%, Glycerine, U.S.P., 10%, Purified Water, U.S.P., de-ionized, q.s. buffered to approximate pH of 4.6: They come in jars of 40 pads. Ready prepared Tucks can be kept by the patient's bedside for immediate application whenever their soothing, healing properties are indicated.

#### Fuller Shleld\*

Protective dressing to hold anal, perlanal and sacral dressing comfortably in place; prevent soiling of clothing or linens with wound drainage, watery fecal leakage, staining medications. Does not bind. No tape needed. Fits male or female patients, waist sizes 24 to 48. Order two per patient; one to launder while other is worn.

For clinical trial supply write to:



## ICN Canada Ltd.

675 Montée de Liesse, Montreal 377, P.Q.

\*Trade marks of Fuller Laboratories, Inc.

#### books

and an adequate bibliography to complement her discussions.

This is a valuable book for all obstetrical departments. It emphasizes the important aspects of newborn care, such as providing warmth, protection from infection, loving care, and close observation. It includes parents by emphasizing an understanding of their culture and giving supportive care and education aimed at improving the care they give to their child.

High-Risk Newborn Infants: The Basis for Intensive Nursing Care by Sheldon B. Korones. 245 pages. Saint Louis, Mosby, 1972. Reviewed by Doris Davidson, Spe-

cial Intensive Care Unit, Grace Maternity Hospital, Halifax, N.S.

The purpose of this text is to acquaint the nurse with neonatal nursing: to give a background and reference book for the care of the high-risk infants; to give nurses the understanding and knowledge necessary to cope with everyday problems arising with such infants; and to help her identify problems before they become crises.

The book's most valuable point is its organization with a teaching approach; its value could extend to other members of the medical team as well as nurses. I hope the second part of the title will not discourage physicians-in-training from using the book.

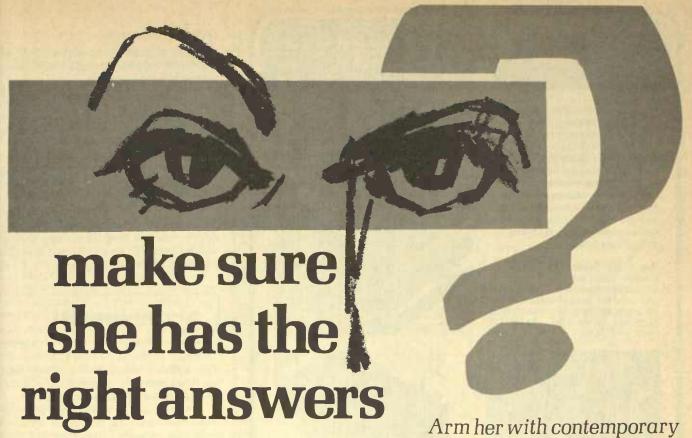
The author, however, expresses some questionable views involved with neonatal nursing. For instance, the author lists chloramphenicol as a medication resulting in fetal death. But is there any evidence that normal doses of chloramphenicol given to expectant mothers will cause death of the fetus or newborn

Radiant heaters presently available do not prevent neonatal temperature fall. An adequate incubator is a prime necessity for environmental control when working with a potentially highrisk newborn or a newborn already in difficulty.

It has been noted that hypoglycemia can occur earlier than two hours of age. Further causes of hypoglycemia have been noted: congenital heart disease, hypervolemia, intrauterine infection, and toxemia, in addition to prematurity.

There is now evidence that phototherapy is important in decreasing bilirubin associated with Rh hemolytic

(Continued on page 56)



Mosby texts that reflect today's latest thinking in professional nursing!

A New Book! THE PROCESS OF PLANNING NURSING CARE: A Theoretical Model, by Fay L. Bower, R.N., B.S., M.S.N. Providing thought-provoking preparation for your students' future clinical responsibilities, this new book aims at developing skill in independent judgment and increasing the ability to assume responsibilities for primary health care. Stressing a holistic approach to patient care, this practical new volume helps the student realize each patient's unique situation and respond accordingly. Important discussions deal with problem identification, decision making and the evaluation of patient response. October, 1972. 139 pages plus FM 1-XII, 6" x 9", 12 illustrations. \$4.15.

A New Book! HIGH-RISK NEWBORN INFANTS, The Basis for Intensive Nursing Care, by Sheldon B. Korones, M.D.; Jean Lancaster, R.N., M.N.; and Florence Bright Roberts, R.N., M.N. Help your students understand the complex "why's" behind newborn abnormality. This new text explains the principles and rationale behind neonatal care that will enable the nurse to develop the accurate efficiency demanded in high-risk situations. In one convenient source, it clearly outlines the rationale of required maneuvers in the neonatal intensive care unit, the significance of laboratory data, how to detect abnormal signs, and much more. July, 1972. 245 pages plus FM 1-XV1, 6½" x 9½", 46 illustrations. \$8.95.

A New Book! A COMMONSENSE APPROACH TO CORONARY CARE: A Program, by Marielle Ortiz Vinsant, R.N., B.S.; Martha I. Spence, R.N., B.S., M.N.; and Dianne E. Chapell, R.N., B.S. Focusing on major problems associated with myocardial infarction, this new program allows students to prepare realistically and systematically for their responsibilities in coronary care. Through an approach based on a thorough knowledge of normal anatomy and physiology, it demonstrates how to deduce the clinical consequences of pathologic changes. Each carefully prepared unit depends on previous ones, resulting in a meaningful integration of information that enables the student to assume coronary care with confidence. October, 1972. 222 pages plus FM I-XIV, 7" x 10", 243 illustrations. \$6.25.

New 2nd Edition! A PROGRAMMED INTRODUCTION TO MICROBIOLOGY, by Stewart M. Brooks. Save class time and increase comprehension of text and lecture with the extensive revision of this popular programmed manual. Including the latest microbiological thinking, particularly in the areas of genetics, biochemistry, immunity and disease, all frames have been restructured for maximum teaching efficiency. All areas of a basic course are included, from fundamentals and practical applications to microorganisms and disease. Its easy-to-use format adapts effectively to use with any current microbiology text. March, 1973. 2nd edition, 124 pages plus FM I-X, 7" x 10", 31 illustrations. About \$5.50.

A New Book! UNDERSTANDING ELECTROCARDIOGRAPHY: Physiological and Interpretive Concepts, by Edwin G. Zalis, M.D., F.A.C.P., F.C.C.P., and Mary H. Conover, R.N., B.S.N.Ed. The comprehensive explanation of basic heart anatomy and the detailed discussion of all aspects of electrocardiography mark the significance of this well-detailed new text. Physiological interrelationships of all major heart functions are delineated, then redefined in light of all the muscle action's electrical potentials. Your students learn how and why muscle movement can be processed electronically into various types of visual graphs. Electrocardiography equipment is discussed in depth. August, 1972. 192 pages plus FM I-XII, 7" x 10". \$6.05.

Instructor's note: To receive a complimentary copy for firsthand evaluation, write to the Textbook Department, mentioning your position, course, and enrollment.

## MOSBY TIMES MIRROR

THE C.V MOSBY COMPANY LTO B6 NORTHLINE ROAD TORONTO 374, ONTARIO, CANADA

## **POSEY SAFETY VESTS**

The Posey Patient Restrainer is one of the many products which compose the complete Posey Line. Since the introduction of the original Posey Safety Belt in 1937, the Posey Company has specialized in hospital and nursing products which provide maximum patient protection and ease of care. To insure the original quality product, always specify the Posey brand name when ordering.

The Posey Patient Restrainer with shoulder loops and extra straps keeps the patient from falling out of bed and provides needed security. There are eight different safety vests in the complete Posey Line. #5163-3131 (with ties), \$7.80.





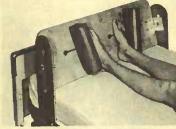
The Posey Disposable Limb Holder provides desired restraint at low cost. This is one of fifteen limb holders in the complete Posey Line. #5163-2526 (wrist), \$19.50 doz. pr.



The Posey Retractable Stretcher Belt can be adjusted to fit eyery stretcher, guerney or operating table. This is one of seventeen safety belts in the complete Posey Line. #5163-5605 (non-conductive), \$24.00 set.



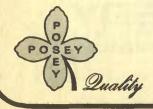
The Posey Keylock Safety Belt is designed with a revolutionary new keylock buckle which can be adjusted to an exact fit and snap locked in place. This belt is one of seventeen Posey safety belts designed for patient comfort and security. #5163-1333 (with snap ends), \$18.00.



The Posey Footboard fits any standard size hospital bed and is fully adjustable to any comfortable angle. Helps prevent foot drop and foot rotation. Complete Posey Line includes twenty-three rehabilitation products. #5163-6420 (footboard only), \$39.00.

Send for the free all new 1970 POSEY catalog - supersedes all previous editions.

Please insist on Posey Quality - specify the Posey Brand name.



Send your order today!

POSEY PRODUCTS
Stocked in Canada
ENNS & GILMORE LIMITED

1033 Rangeview Road Port Credit, Ontario, Canada (Continued from page 54)

disease; a short word about early intrauterine transfusion and early induction would be in order.

More emphasis should have been placed on mental retardation and cerebral damage associated with breech deliveries, stressing the value of good obstetric care.

For once the importance of skilled personnel is stressed, allowing the qualified nurse to become a valuable member of the medical team.

Generally, this text is the best synopsis of neonatology so far available. A copy on the hospital library shelves will be valuable to nurses and all other members of the medical team.

#### accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, except reference items may be borrowed by CNA members, schools of nursing and other institutions. Reference (R) items (archive books and directories, almanacs and similar basic books) do not go out on loan. Theses (also R) are on reserve and may go out on interlibrary loan only.

Request for loans should be made on the "Request Form for Accession List" and should be addressed to: The Library, Canadian Nurses' Association, 50 The Driveway, Ottawa, Ont. K2P 1E2.

No more than *three* titles should be requested at any one time.

BOOKS AND DOCUMENTS

- 1. Air pollution primer. New York, National Tuberculosis and Respiratory disease Association, 1969. 104p.
- 2. Application procedures for out-of-province teachers seeking certificates and evaluation of their qualifications. Ottawa, Canadian Teachers' Federation, 1972, 99p.
- 3. Clinical instructor training program; trainer's manual, by Miles H. Anderson, Rev. Los Angeles, University of California in cooperation with U.S. Dept. of Health, Education and Welfare, Social and Rehabilitation Service, 1970, 93p.
- 4. Creating a climate for educational technology in nursing. by Evelyn M. Lutz and Jeanne S. Berthold. Cleveland, Ohio, Frances Payne Bolton School of Nursing, Case Western Reserve University, 1971. 100p.
- 5. Détente psycho-musicale en odonto-stomatologie; musique et sophrologie relation médecin-malade, par M. Gabai et J. Jost. Paris, Maloine, 1972. 158p.
- 6. Emergency services; the hospital emergency department in an emergency care

system. Chicago, American Hospital Association, 1972, 98p.

7. Enquête préliminaire sur la situation de l'emploi chez les infirmières du Canada en vue de déterminer le nombre d'emplois disponibles pour les diplômées des écoles canadiennes d'infirmières, inscrites/autorisées pour la première fois en 1971, qui n'avaient pas réussi à trouver un emploi permanent dans le monde infirmier, au 30 septembre 1971. Ottawa, Association des Infirmières canadiennes, 1971. 1 vol.

8. For patient's sake, by Mildred 1. Moe. Minneapolis, Minn., Geriatric Care, 1972. 9. Health and human values: an ecological

approach, by Allure Jefcoat. Toronto, Wiley, 1972, 255p.

10. The health theme in family planning, by Abdel R. Omran. Chapel Hill, N.C., Carolina Population Center, University of North Carolina, 1971. 156p. (Carolina Population Center monograph no. 16)

11. A health sciences library basic manual for library staff in small health care institutions. Edited by Sheila C. Maxwell. Toronto, Ontario Medical Association, 1972. 95p.

12. Learning and leisure in middle and later life, by Enid Hutchinson, London, Pre-Retirement Association, 1970, 56p.

13. Loisirs des femmes et temps libre, par France Govaerts. Bruxelles, Université libre de Bruxelles, 1969. 312p.

14. Maladies cérébro-vasculaires: prévention, traitement et réadaptation. Genève, Organisation Mondiale de la Santé, 1971. 63p. (1ts Série de rapports techniques no. 469)

15. Nouvelles perspectives en psychologie, par L. Astruc. Paris, Maloine, 1972. 151p.

16. Nurse teachers; the report of an opinion survey, by A. Lancaster. Edinburgh, Churchill Livingstone, 1972. 146p. (Edinburgh. University. Dept. of Nursing Studies monograph no. 2)

17. A nurse's guide to anaesthetics, resuscitation and intensive care, by Walter Norris and Donald Campbell, 5ed, Edinburgh, Churchill Livingstone, 1972. 181p.

118. A nurse's guide to the x-ray department, by Myer Goldman. 2ed. Edinburgh, Churchill Livingstone, 1972. 87p.

19. Nursing in child psychiatry, by Claire Mintzer Fagin. St. Louis, Mosby, 1972. 183p.

20. Nursing in the intensive respiratory care unit, by Hannelore Sweetwood. New York, Springer, 1971. 208p.

21. Patient care studies in medical-surgical nursing, by Wilma J. Phipps and Rosemary Rich. St. Louis, Mosby, 1972, 193p.

22. The Penguin medical encyclopedia, by Peter Wingate. Harmondsworth, Eng., Penguin Books, 1972, 463p.

23. Proceedings of the Canadian Conference on Social Welfare, Toronto, June 15-19, 1970. Ottawa, Canadian Council on Social Development, 1971. 74p.

24. The profession of dietetics; report of the Study Commission on Dietetics. Chicago, American Dietetic Association, 1972. 110p.

25. A psychological approach to the prediction of contraceptive behavior, by Virupaksha Kothandapani. Chapel Hill, N.C., Carolina Population Center, University of North Carolina, 1971. 96p. (Carolina Population Center monograph no. 15)

26. Qualitative evaluation of family planning proposals and programs: a systems approach, by Curtis P. McLaughlin and Edward S. Trainer. Chapel Hill, N.C., Carolina Popuation Center, University of North Carolina, 1971. 70p. (Carolina Population Center monograph no. 12)

27. Report 1970. New York, Milbank Memorial Fund, 1971. 50p.

28. Teaching the mentally retarded child; a family care approach, by Kathryn E. Barnard and Marcene L. Powell. St. Louis, Mosby, 1972. 158p.

29. Techniques for utilizing nursing principles, by Marion Brown Gooding. St. Louis Mosby, 1972. 163p.

30. To the author in search of a publisher; a practical plan for the publication and promotion of your book. New York, Vantage Press, 1971. 48p.

31. Training of research workers in the medical sciences; proceedings of a Round Table Conference organized by CIOMS with the assistance of WHO and UNESCO, Geneva, 10-11 Sept. 1970. Geneva, World Health Organization, 1972, 186p.

32. Unplanned pregnancy; a report of the Working Party of the Royal College of Obstetricians and Gynecologists on Unplanned Pregnancy. London, Royal College of Obstetricians and Gynecologists, 1972.

33. The use of cannabis; report of a WHO Scientific Group. Geneva, World Health Organization, 1971. 47p. (Its Technical report series no. 478)

34. The work of WHO 1971. Annual report of the director-general to the World Health Assembly and to the United Nations. Geneva World Health Organization, 1972. 401p.

#### PAMPHLETS

35. Code des professions, Bill 250; loi des infirmières et infirmiers, Bill 273. Montreal, Association des Infirmières et Infirmiers de la Province de Québec, 1972.

36. Criteria for the appraisal of baccalaureate and higher degree programs in nursing, 1972. New York, National League for Nursing, Dept. of Baccalaureate and Higher Degree Programs, 1972. 10p.

37. Hospital library administration, by Anne Cramer. Salt Lake City, Network for Continuing Education, Intermountain Regional Medical Program, 1971. 25p. (Hospital library handbook no. 1)

38. Human development and public health; report of a WHO Scientific Group. Geneva. World Health Organization, 1972, 40p. (1ts Technical report series no. 485)

39. Nutrition: a review of the WHO programme 1965-1971. Geneva World Health Organization, 1972, 35p.

40. Professional code, Bill 250; nurses act,



#### accession list

*Bill 273.* Montreal, Association of Nurses of the Province of Quebec, 1972.

41. Sibling visiting program, by M. Lorna Hood. Calgary, Alta., Foothills Hospital. Dept. of Obstetrics, 1972, 7p.

#### GOVERNMENT DOCUMENTS

Canada

42. Commission de réforme du droit. La preuve. Documents préliminaires de la section de recherche sur le droit de la preuve. Ottawa, 1972, 1 vol.

43. Dept. of Manpower and Immigration. The nursing profession in Mexico. Ottawa, 1972. 16p.

44. Dept. of National Health and Welfare. Collection of material on smoking and health. Ottawa, 1972, 1 vol.

45. Economic Council of Canada. New approaches to public decision-making, by Alice M. Rivlin. Ottawa, Information Canada, 1972. 37p. (Its Special study no. 18)

46. Ministère de la Santé nationale et du Bien-être social. Rapport sur l'application des accords avec les provinces au titre de la loi sur l'assurance-hospitalisation et les services diagnostiques pour l'année financière terminée le 31 mars 1971. Ottawa, 1972.

47. Law Reform Commission. Study papers prepared by the Law of Evidence Project, August 1972. Ottawa, 1972. I vol.

48. Statistics Canada. Census of Canada, 1971. Ottawa, 1972. 1 vol. R

49. Statistique Canada. Rapport annuel sur les maladies à déclaration obligatoire, 1971. Ottawa, Queen's Printer, 1972. 1 vol.

Ontario

50. Commission on Post-Secondary Education. Certification and post-secondary education; a study prepared for the Commission on Post-Secondary Education in Ontario. Toronto. Queen's Printer, 1972, 109p.

51. Cost and benefit study of post-secondary education in Ontario, school year 1968-69; a study prepared for the Commission on Post-Secondary Education in Ontario. Queen's Printer, 1972. 1 vol.

52. Financing post-secondary education; a study prepared for the Commission on Post-Secondary Education in Ontario. Toronto, Queen's Printer, 1972, 157p.

53. Libraries and information storage and retrieval systems; a study prepared for the Commission on Post-Secondary Education in Ontario. Toronto, Queen's Printer, 1972. I vol.

54. Manpower forecasting and educational policy; a study prepared for the Commission on Post-Secondary Education in Ontario. Toronto, Queen's Printer, 1972. 267p.

55. Commission on Post-Secondary Education. Manpower retraining programs in Ontario; a study prepared for the Commission on Post-Secondary Education in Ontario, Toronto, Queen's Printer, 1972, 195p.

56. Ontario Colleges of Applied Arts and Technology; a study prepared for the Commission on Post-Secondary Education in Ontario. Toronto, Queen's Printer, 1972.

57. Organization of the academic year; a study prepared for the Commission on Post-Secondary Education in Ontario. Toronto, Queen's Printer, 1972. 213p.

58. Professional education: a policy option; a study prepared for the Commission on Post-Secondary Education in Ontario. Toronto, Queen's Printer, 1972. 158p. United States

59. Division of Nursing. Cooperative planning for a school of nursing within a health science complex, by Elizabeth J. Worthy and Dorothy M. Crawley. Bethesda, Md., 1970. 26p.

STUDIES DEPOSITED IN CNA REPOSITORY COLLECTION

60. A conceptual model for the provincial nursing consultant in Alberta, by Fernande Harrison. Edmonton, 1972. 118p. (Thesis (M.H.S.A.) — Alberta) R

61. Transfer of functions, a report of the Joint Committee CHA|CMA|CNA on the Transfer of Functions between Doctors and Nurses in the Hospital. Toronto, Canadian Hospital Association, 1972. 59p. (Canadian Hospital Association. Committee research report no. 2)



Registered Nurses and R.N.A.'s required HOSPITAL

260 bed (expanding to 415) accredited, modern, general hospital, with progressive patient care, including a 5 bed coronary care unit 5 bed I.C.U., 22 bed Psychiatric and 24 bed Self-care unit.

#### IDEAL LOCATION

45 minutes from downtown Toronto, 15-30 minutes from excellent summer and winter resort areas.

#### FURNISHED APARTMENTS

Swimming pool, tennis court, etc. (see above)
OTHER BENEFITS:

Medical and hospital insurance, pension plan, etc.

Please address all enquiries to:
Director of Nursing,
YORK COUNTY HOSPITAL
596 Davis Drive,
NEWMARKET, Ontario.

# Request Form for "Accession List"

# CANADIAN NURSES' ASSOCIATION LIBRARY

Send this coupon or focsimile to: LIBRARIAN, Canadian Nurses' Association, 50 The Driveway, Ottawa K2P 1E2, Ontario.

Please lend me the following publications, listed in the issue of The Canadian Nurse, or add my name to the waiting list to receive them when available.

Item No.	Author	Short title	(for	identification
-------------	--------	-------------	------	----------------

Reference and restricted CNA library.	filled in order of receipt. material must be used in the
Borrower	The service of the service of the service of
Registration No.	

Position Address

Date of request

# The Canacian Nurse

March 1973



whose baby is 1

ten tips for preparing research proposals

UNIVERSITY OF OTTAWA OTTAWA, OUT. KIN 6N5 IR-73-10-71-CM-INV, 3087



### THE SWEATER FASHIO

IN FOR SPRI

FROM





#40998 — "Royale Supreme" plain tricot combined permanently tucked tricot to give the career girl sweater fashion with a swing skirt.

"ROYALE SUPREME" combined with permanently tucked knit polyester blended with nylon

Sizes 3-13. White only ..... about \$





SEE LIST
OF PROMINENT
/HITE SISTER DEALERS
ON
INSIDE BACK COVER

CNA members are eligible for Scholarsi ips from the CANADIAN NURSES' FOUNDATION.
THE WHITE SISTER UNIFORM INC. SCHOLAR HIP FUND sponsors one of these awards.

#### **BASIC SCIENCES**

BASIC PHYSIOLOGY AND ANATOMY

Chaffee-Greisheimer

\$10.50 1969 LABORATORY MANUAL IN

PHYSIOLOGY AND ANATOMY

Chaffee

\$3.90 1969

BASIC MICROBIOLOGY

Volk-Wheeler

abt. \$12.50 June 1973

LABORATORY EXERCISES

IN MICROBIOLOGY

Otero

June 1973 abt. \$5.25

TEXTBOOK OF

**PATHOPHYSIOLOGY** 

Snively-Beshear

1972 \$11.25

#### **FUNDAMENTALS**

**FUNDAMENTALS OF** NURSING

Fuerst-Wolff

1969 \$8,00

NURSING CARE PLANNING

Little-Carnevali

1969 paper \$4.15

cloth \$6.00

**NURSING MANAGEMENT** 

OF THE PATIENT

WITH PAIN

McCafferv

1972 \$5.25

SCIENTIFIC FOUNDATIONS

OF NURSING

Nordmark-Rohweder \$5.00

PERSPECTIVES IN HUMAN

**DEVELOPMENT: Nursing** 

Throughout the Life Cycle

Sutterley-Donnelly

April 1973 abt. \$7.95

#### NUTRITION

**NUTRITION IN NURSING** 

Anderson et al

1972 \$8.00

COOPER'S NUTRITION IN

HEALTH AND DISEASE

Mitchell et al

1968 \$9.50 **AUDIO/VISUAL TEACHING** AIDS? NEW! MULTI MEDIA **COURSES FOR SELF** INSTRUCTION. ALSO, FILM STRIPS AND FILM LOOPS AVAILABLE.

# LOOK TO LIPPINCOTT **PROVEN** URSING

Serving the Health Professions in Canada since 1897.



WRITE FOR CATALOGS AND DESCRIPTIVE BROCHURES.

J. B. LIPPINCOTT COMPANY OF CANADA LTD.

75 Horner Ave. Toronto 18, Ontario

#### MEDICAL-SURGICAL

TEXTBOOK OF MEDICAL-SURGICAL NURSING

Brunner et al

1970 \$14.95

CARE OF THE ADULT PATIENT

Smith-Germain-Gips

1971 \$13.95

NURSING OF ADULTS

Smith-Germain

1972 \$9.95

ADVANCED CONCEPTS IN **CLINICAL NURSING** 

Kintzel et al

1971 \$14.50

CRITICAL CARE NURSING

Hudak-Gallo-Lohr

**April 1973** abt. \$9.95

#### PHARMACOLOGY

PHARMACOLOGY AND DRUG THERAPY IN NURSING

Rodman-Smith

1968 \$10.75

#### MATERNAL CHILD

**MATERNITY NURSING** 

Fitzpatrick-Reeder-Mastroianni 1971 \$10.95

**NURSING CARE OF** 

CHILDREN

Blake-Wright-Waechter

1970 \$10.50

**EMOTIONAL CARE OF** 

HOSPITALIZED CHILDREN

Petrillo-Sanger

1972 paper \$5.75

cloth \$8.00

**FOUNDATIONS OF** PEDIATRIC NURSING

Broadribb

1973 paper \$7.95

#### **PSYCHIATRIC** NURSING

BASIC PSYCHIATRIC **CONCEPTS IN NURSING** 

Hofling et al

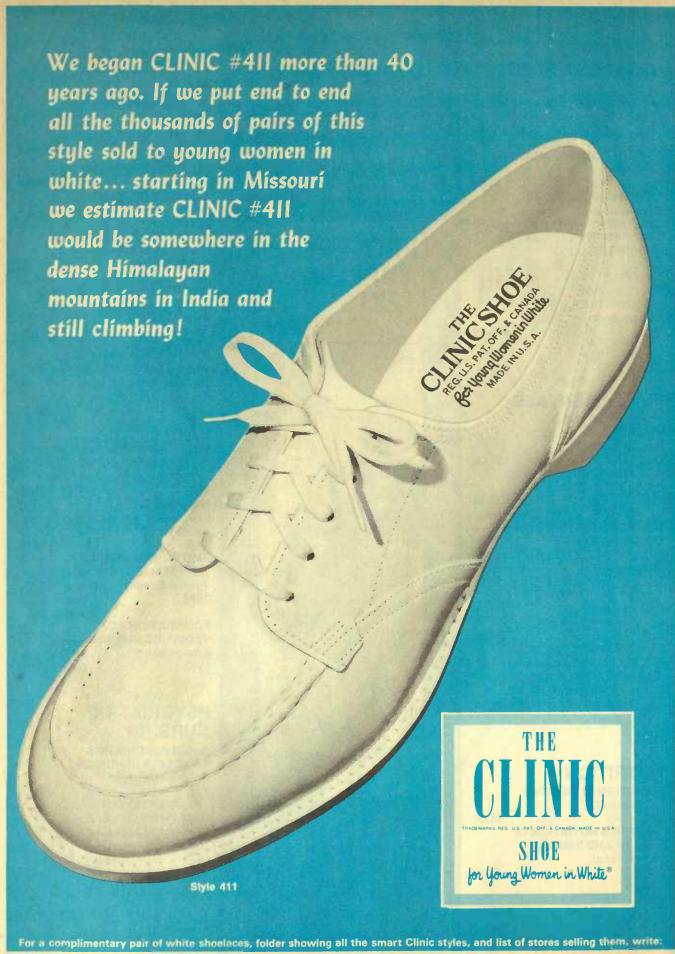
1967 \$7.90

THE PRACTICE OF MENTAL **HEALTH NURSING: A** 

**Community Approach** 

Morgan-Moreno 1973

paper abt. \$5.95 cloth abt. \$7.50



# The Canadian Nurse



A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 69, Number 3

March 1973

- 23 CNA Financial Statement
- 27 Whose Baby Is This? ..... L. Baizley
- 30 Ten Tips on Preparing Research Proposals ................. W.O. Spitzer
- 34 Gestational Diabetes When Teaching is Important ....... E. Laugharne, F. Duncan
- 37 Idea Exchange

The views expressed in the editorial and various articles are those of the authors and do not necessarily represent the policies or views of the Canadian Nurses' Association.

- 4 Letters
- II News
- 42 New Products
- 44 Dates
- 46 Names

- 50 Research Abstracts
- 51 Books
- 55 AV Aids
- 56 Accession List
- 72 Index to Advertisers

Executive Director: Helen K. Mussallem • Editor: Virginia A. Lindabury • Assistant Editors: Liv-Ellen Lockeberg, Dorothy S. Starr • Editorial Assistant: Carol A. Dworkin • Production Assistant: Elizabeth A. Stanton • Circulation Manager: Beryl Darling • Advertising Manager: Georgina Clarke • Subscription Rates: Canada: one year, \$6.00; two years, \$11.00. Foreign: one year, \$6.50; two years, \$12.00. Single copies: .75 cents each. Make cheques or money orders payable to the Canadian Nurses' Association. • Change of Address: Six weeks' notice; the old address as well as the new are necessary, together with registration number in a provincial nurses' association, where applicable. Not responsible for journals lost in mail due to errors in address.

Manuscript Information: "The Canadian Nurse" welcomes unsolicited articles. All manuscripts should be typed, double-spaced, on one side of unruled paper leaving wide margins. Manuscripts are accepted for review for exclusive publication. The editor reserves the right to make the usual editorial changes. Photographs (glossy prints) and graphs and diagrams (drawn in india ink on white paper) are welcomed with such articles. The editor is not committed to publish all articles sent, nor to indicate definite dates of publication.

Postage paid in cash at third class rate MONTREAL, P.O. Permit No. 10,001. 50 The Driveway, Ottawa, Ontario. K2P 1E2 Canadian Nurses' Association 1973.

#### Message from President

of the

#### Canadian Nurses' Association

The Canadian Nurses' Association's goals for 1972-1974 have been outlined. Goals serve as vantage points to assess the direction we should take. Priorities need to be assessed, and programs for action must be developed.

But where will the future take us? Even more pertinent is the question: Do we have a future? Some of my colleagues in the mental health setting are beginning to doubt that nurses will be included in the mental health care team of tomorrow! If our future appears to be so nebulous, then we each have a responsibility to define and assess alternative futures. We must work to alter trends.

At the CNA board meeting in January 1973, at least three major decisions were made that could influence the future. The first was to make plans for a national conference on nursing this fall to examine the preparation of the nurse beginning at the diploma level. Those involved in nursing practice and in nursing education will participate. Undoubtedly, the need for specialization will be considered at this conference.

The second decision was that the CNA would take steps to explore, in collaboration with other disciplines, the feasibility and timeliness of a national system of accreditation for nursing education.

In its third decision, the board declared its position on the role of the nurse in a primary care setting. This position is now being examined by a joint committee of the CNA and the Canadian Medical Association.

What tomorrow holds depends on each of us — on what we foresee, on what we believe, and on what we do. Freedom of choice goes hand in hand with controversy. Airing of differences is a necessary step toward a more cohesive view of what we desire.

The programs to be developed to achieve our goals will provide for nurses and members of other disciplines an opportunity to deliberate, to be open about differing viewpoints, and, we hope, to plan the future. Then, depending on what we do today, five or ten years from now we will have only ourselves to praise or blame!

- Marguerite E. Schumacher

# letters

Letters to the editor are welcome.

Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Comments on registration

In response to G.E. Ryan, "Grad of '47 for women's lib" (Letters, January 1973, page 8), I sympathize but find that for Nova Scotia, at least, a marriage certificate is necessary only if a nurse is registered in her maiden name.

As an English RN, I would like to add a few comments concerning registration in the different provinces of

Canada.

I have worked in several provinces, but the process I have had to go through to get registered! Each time I have had to write to my nurse training school in England for my transcripts. I know this applies to all landed immigrants who wish to nurse and are eligible. Surely once a nurse is registered in one province, transcripts could be transferable from province to province.

Each province has its own set of regulations. Nova Scotia, for example, even requires confirmation of one's RN registration from the specific registration board or council. British Columbia requires the applicant to have been resident in a Canadian province for three months! Yet to work, a nurse is supposed to be registered; if not, she loses status, as well as at least \$25 a month.

I am married now to a Canadian, so I may continue to move around Canada. I wonder how long my transcripts will be kept in England? — Elisabeth J. Storey, S.R.N., S.C.M., Halifax, Nova Scotia.

#### Kind of article we need

The article "Choosing Contraceptives According To Need" by Nancy Garrett, which appeared in the September 1972 issue, is the kind of article we need today. Congratulations and thank you!

I would like to see articles like this available in schools and doctors' offices. — Mary Goodfellow Groome,

RN, Laval, Quebec.

#### Criticizes book review

The review of the book Medical-Surgical Nursing and Related Physiology by Jeannette E. Watson (Books, December 1972, page 50) does a disservice to the nurses of Canada who use The Canadian Nurse as a source of information on new publications.

A more informative review of this book is included in the January 1973 issue of the American Journal of Nursing. The review is in the section entitled "Books of the Year." Nursing experts in the United States selected these books as being the most significant in their areas of practice.

The Canadian Nurse can and should give merited recognition and encouragement to Canadian contributors to the nursing literature. Praise from non-Canadian sources is not enough. — Marion I. Barter, Toronto, Ontario.

Attention graduates of Miramichi

The last graduation of the Miramichi Hospital School of Nursing will be held Friday June 8, 1973, at 8:15 P.M. in the Lord Beaverbrook Theatre and Town Hall, Newcastle, New Brunswick.

On June 9, a luncheon honoring all graduates of the school will be held at 1:30 P.M., and a dance, starting at 9:00 P.M., will be held in the Lord Beaverbrook Theatre and Town Hall.

All graduates from 1920 to 1973 are invited to attend all functions. Please notify me no later than April 30, 1973, if you plan to attend. -Anna M. Allison, RN, director of nursing, Miramichi Hospital, Newcastle, New Brunswick.

#### Maternal and child welfare

Having recently attended a seminar in Toronto on family-centered maternity care with Doreen Jordan, I have two thoughts uppermost in my mind.

First, there appears to be a pitiful lack of communication among members of the team involved in maternal and child welfare. Second, there are few aspects of health care that offer such a tremendous opportunity for developing a comprehensive plan of preventive medicine.

The high level of audience participation at the seminar, both during and between the sessions, prompts me to suggest that steps be taken to have more such meetings. Perhaps an organization, similar to the one for operating room and central supply room staffs, could be formed in Ontario for nurses interested in maternal and child welfare. I believe this would be better than just being connected with the American College of Obstetricians and Gynecologists. Our future is in our own hands. I am sure that executive and resource personnel at both provincial and federal levels would assist such a move.

The maternal and child health care team can help pull Canada up from her number 14 spot and place her among the world's leaders. Are there enough who are sufficiently aware become involved? — Diana K. Ballard, R.N., Obstetrical Supervisor, Campbellford, Ontario.

#### More women needed in medicine

Thank you for printing the paper "Needed: a change in attitudes toward elective sterilization" (January 1973), which Dr. Lise Fortier presented at the meeting of the International Planned Parenthood Federation in Ottawa.

Such an article points out the great need for more women in the medical profession and the need for obstetrics and gynecology to be dominated by women. More women should be encouraged to study medicine, and medical schools should strive for an equal number of women and men in their student populations. — Margery L. Poole, B.Sc.N., Toronto, Ontario.

Research on handicapped nurses

I am doing research for an article about what happens to a nurse who develops a handicap. In most professions, there is some place in their ranks for a member who develops a handicap.

Is there any place for the handicapped RN — one who becomes hard-of-hearing, blind, or otherwise limited physically?

I would like to hear from any nurses who have developed disabilities or from any who have been involved with such persons. Correspondence should be sent to mc. - Marilyn O. Dahl, 1457 Morrison St., Port Coquitlam, B.C.

Writing biography

I have been asked by the New Zealand Nursing Education and Research Foundation to write a biography of the late Mary Lambie. She was director, division of nursing, in New Zealand, and was well known for many years for the part she played in international nursing affairs.

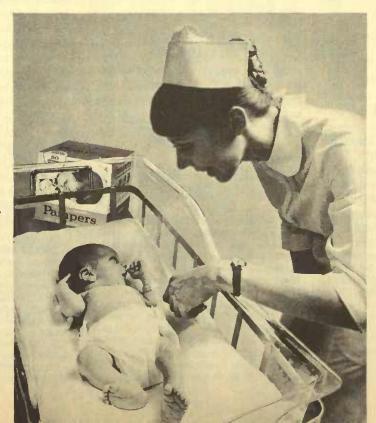
I am asking anyone who has recollections of Ms. Lambie, which might be of interest, to communicate with me. I would be most grateful for any information or personal recollections. — Helen Campbell, 5 Le Awakura Terrace, St. Andrew's Hill, Christchurch 8, New Zealand.

**MARCH 1973** 

# Pampers Pampers oives uboth abreak

# Keeps him drier

Instead of holding moisture, Pampers hydrophobic top sheet allows it to pass through and get "trapped" in the absorbent wadding underneath. The inner sheet stays drier, and baby's bottom stays drier than it would in cloth diapers.



# Saves you time

Pampers construction helps prevent moisture from soaking through and soiling linens. As a result of this superior containment, shirts, sheets, blankets and bed pads don't have to be changed as often as they would with conventional cloth diapers. And when less time is spent changing linens, those who take care of babies have more time to spend on other tasks.

PROCTER & GAMBLE

# THE SPIRIT OF '73

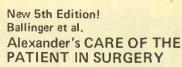
New Mosby texts march to the beat of a



# New 2nd Edition! Redman THE PROCESS OF PATIENT TEACHING IN NURSING

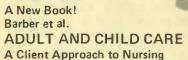
Teaching the patient and his family is an integral part of nursing care. This new edition will teach your students how to judge what their patient needs to know about the cause and care of his condition, when he is most ready to learn, and how best to teach him.

By BARBARA KLUG REDMAN, R.N., B.S.N., M.Ed., Ph.D., Associate Professor of Nursing, University of Minnesota School of Nursing, Minneapolis, Minn. May, 1972. 2nd edition, 178 pages plus FM I-X, 6½" x 9½". Price, \$8.35.



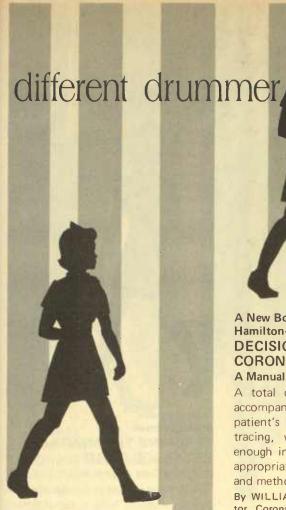
A leading text in its field, this new edition defines the dimensions of professional nursing responsibility in the operating room — from design of the surgical suite to current techniques and procedures for specific types of surgery.

By WALTER F. BALLINGER, M.D., Bixby Professor of Surgery and Head of the Department, Washington University School of Medicine, St. Louis, Mo.; JACQUELYN C. TREYBAL, R.N., Assistant Director, Barnes Operating Rooms, Barnes Hospital, St. Louis, Mo.; and ANN B. VOSE, R.N., B.S.N., M.S., Director, Department of Nursing Service, University of Michigan Medical Center, Ann Arbor, Mich.; with 17 contributors. December, 1972. 5th edition, 905 pages plus FM I-XVIII, 7" x 10", 2,490 illustrations in 680 figures, 2 in full color. Price, \$20.25.



For the first time, adult and pediatric medical-surgical nursing are combined in one text. Taking the client approach, the nurse/authors focus on health care throughout the life cycle, contending that nurses minister to five basic human needs regardless of the client's age. After the theories are presented and fully developed, they become the basis for a highly practical 880 pages of procedural instruction. The authors cover everything from the nurse practitioner's expanding duties to evacuation of a hospital in case of fire

By JANET MILLER BARBER, R.N., M.S., Associate Professor of Nursing, Baccalaureate Program, Indiana-Purdue University at Indianapolis, Ind.; LILLIAN GATLIN STOKES, R.N., M.S., Assistant Professor of Nursing, Indiana-Purdue University at Indianapolis, Indianapolis, Ind.; and DIANE McGOVERN BILLINGS, R.N., M.S., Assistant Professor of Nursing, Indiana-Purdue University at Indianapolis, Ind. June, 1973. Approx. 880 pages, 8" x 10", 516 illustrations. About \$15.50.



New 2nd Edition! **Bouchard-Owens** NURSING CARE OF THE **CANCER PATIENT** 

This new text explains cancer's effects on all major body systems. The authors discuss the three traditional cancer therapies, and detail nursing approaches to each. Special consideration is given to the psychological aspects of primary and advanced disease, for the patient, his family, and the nurse.

By ROSEMARY BOUCHARD, A.B., A.M., Ed.D., R.N., Assistant Professor, Department of Nursing Education, Queensborough Community College of the City University of New York, Bayside, N. Y.; and NORMA F. OWENS, A.B., A.M., Ed.D., R.N., Associate Professor and Director, Biophysical Pathology, Division of Nurse Education, New York, N. Y. October, 1972. 2nd edition, 290 pages plus FM I-XIV, 7" x 10", 196 illustrations. Price, \$13.15.

#### MOSBY TIMES MIRROR

THE C. V. MOSBY COMPANY, LTO. 86 NORTHLINE ROAD TORONTO, ONTARIO M4B 3F5



#### A New Book! Hamilton-Lavin **DECISION MAKING IN THE** CORONARY CARE UNIT A Manual and Workbook for Nurses

A total of 123 realistic cases, each accompanied by a description of the patient's total condition and an EKG tracing, will provide students with enough information to determine the appropriate treatment goals, actions, and methods of evaluation.

By WILLIAM P. HAMILTON, M.D., Director, Coronary Care Unit, St. John's Mercy Medical Center, St. Louis, Mo.; and MARY ANN LAVIN, R.N., B.S.N., M.S.N., Assistant Professor of Nursing and Director, Cardiovascular Nursing Program, St. Louis University School of Nursing, St. Louis, Mo. September, 1972. 150 pages plus FM I-X, 7" x 10", 124 illustrations. Price, \$4.50.

#### A New Book! Vinsant et al.

#### A COMMONSENSE APPROACH TO CORONARY CARE

A Program

This programmed guide encourages students to arrive at solutions through reason rather than through memorization. After discussing anatomy and physiology in relation to coronary activity, the authors examine heart failure and shock, diagnosis of an acute MI, and much more.

By MARIELLE ORTIZ VINSANT, R.N., B.S., Coordinator, Coronary Care Unit, and Instructor, Department of Research and Development, Jackson Memorial Hospital, Miami, Fla.; MARTHA I. SPENCE, R.N., B.S., M.N., Clinical Specialist, Coronary and Medical Intensive Care, Jackson Memorial Hospital, Miami, Fla.; and DIANNE E. CHAPELL, R.N., B.S., Nurse Clinician and Coordinator, Medical Intensive Care Unit, Jackson Memorial Hospital, Miami, Fla. October, 1972. 222 pages plus FM I-XIV, 7" x 10", 243 illustrations; original drawings by Marcellino Obaya. Price, \$6.25.



Zalis-Conover UNDERSTANDING **ELECTROCARDIOGRAPHY** 

Physiological and Interpretive Concepts Physiologic interrelationships of all major heart functions are delineated. then redefined in light of the muscle action's electrical potentials. Students learn how and why muscle movement can be processed electronically into various types of visual graphs. Electrocardiography equipment is discussed in

By EDWIN G. ZALIS, M.D., F.A.C.P., F.C.C.P., Director, Coronary Care Unit, Granada Hills Community Hospital, Granada Hills; Northridge Hospital, Northridge; Pacoima Memorial Lutheran Hospital, Lake View Terrace; Serra Memorial Hospital, Sun Valley, Calif.; and MARY H. CONOVER, R.N., B.S.N.Ed., Instructor in Continuing Education, West Hills Hospital and West Park Hospital, Canoga Park, Calif. August, 1972. 192 pages plus FM I-XII, 7" x 10", 341 illustrations, Price, \$6.05.

#### A New Book! Korones HIGH-RISK NEWBORN INFANTS

The Basis for Intensive Nursing Care

This unique text concentrates on the complex "why's" behind newborn abnormality. Respiratory problems, acidbase imbalance - these topics and many more are considered in depth. Students will learn principles and rationale necessary to develop the accurate efficiency demanded in highrisk situations.

By SHELDON B. KORONES, M.D., Professor of Pediatrics, University of Tennessee College of Medicine; Director, Newborn Center, City of Memphis Hospital, Memphis, Tenn.; with the editorial assistance of, and a chapter by JEAN LANCASTER, R.N., M.N.; and FLORENCE BRIGHT ROBERTS, R.N., M.N. July, 1972. 245 pages plus FM I-XVI, 61/2" x 91/2", 46 illustrations. Price, \$8.95.



A New Book!
Weldy
BODY FLUIDS AND
ELECTROLYTES

#### A Programmed Presentation

This question-and-answer format clearly presents basic principles of normal body fluid and electrolytes, common abnormalities, and treatment and nursing care for common imbalances. Fifteen summary and review sections help students evaluate what they have learned.

By NORMA JEAN WELDY, R.N., B.S., M.S., Assistant Professor of Nursing, Goshen College, Goshen, Ind. June, 1972. 101 pages plus FM I-XII, 7" x 10", 24 illustrations. Price, \$4.15.

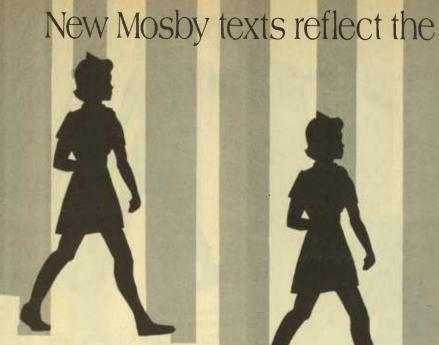
A New Book! Burke

# THE COMPOSITION AND FUNCTION OF BODY FLUIDS

Real problem-solving situations give full coverage to the role of body fluids in maintaining health, and how deviations from normal quantity and composition will affect an individual's well-being. A current bibliography and glossary round out the text.

By SHIRLEY R. BURKE, B.S.N., M.S.N.Ed., Formerly Chairman, Department of Biological Sciences, Presbyterian-University Hospital School of Nursing, Pittsburgh, Pa. August, 1972. 100 pages plus FM I-XII, 6½" x 9½", 21 illustrations. Price, \$3.70.

INSTRUCTOR'S NOTE: To receive a complimentary copy for firsthand evaluation, write to the Textbook Department, mentioning your position, course, and enrollment.



New 2nd Edition!
Brooks
A PROGRAMMED INTRODUCTION TO MICROBIOLOGY

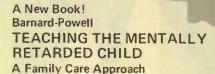
This programmed manual covers: identification of major groups of microorganisms; treatment of major diseases caused by these groups; and applied microbiology. Noteworthy discussions consider genetics, biochemistry, immunity, and disease.

By STEWART M. BROOKS. April, 1973. 2nd edition, 124 pages plus FM I-X,  $7^{\prime\prime}$  x 10", 31 illustrations. About \$5.50.

A New Book!
Fagin
NURSING IN CHILD
PSYCHIATRY

Now, a new text stresses the difference between child and adult needs. With emphasis on the role of nursing intervention, discussions explore introductory concepts of child psychiatry, the problems of latency-aged children, racism, the family as a unit of treatment, and much more!

Edited by CLAIRE M. FAGIN, Ph.D., R.N., Professor and Chairman, Department of Nursing, Herbert H. Lehman College, The City University of New York, Bronx, N. Y.; with 7 contributors. June, 1972. 183 pages plus FM I-XIV, 6" x 9". Price, \$6.05.

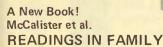


The families of retarded children often require as much help as the children, themselves. This new text presents students with background information on how to meet the abnormal child's needs, as well as methods for helping families learn to cope.

By KATHRYN E. BARNARD, R.N., B.S.N., M.S.N., Ph.D., Professor of Nursing; and MARCENE L. POWELL, R.N., B.S.N., M.N., Assistant Professor; both with University of Washington School of Nursing, and associated with Child Development and Mental Retardation Center, University of Washington, Seattle, Wash. August, 1972. 158 pages plus FM I-XII, 6" × 9". Price, \$4.75



# growing responsibilities of tomorrow's nurse



PLANNING

#### A Challenge to the Health Professions

Twenty-eight articles, in five parts, are integrated via skillful introductions to help students understand the nature of family planning. Stressing both professional and personal implications, it challenges the health care team to increase its involvement in this vital area.

By DONALD V. McCALISTER, B.A., Ph.D., Director, Center for Research in Health Care Delivery, University of Alabama in Huntsville, Huntsville, Ala.; VICTOR THIESSEN, B.A., M.A., Ph.D., Assistant Professor of Sociology, Department of Sociology, Case Western Reserve University, Cleveland, Oh.; and MARGARET McDERMOTT, R.N., B.S.N., M.S.N., Ph.D.(Candidate), Department of Sociology, Case Western Reserve University, Cleveland, Oh. April, 1973. 256 pages plus FM I-XII. 7" x 10", 6 illustrations. About \$6.50.



A New Book! Treece-Treece **ELEMENTS OF RESEARCH** IN NURSING

A practical how-to-do-it manual, this new text offers concise explanations for each step involved in the research process. The relationship between theory and method is treated in depth. Students will find valuable tips for library research, as well as pointers on how to write, report, and publish research findings.

By ELEANOR WALTERS TREECE, R.N., B.A., M.Ed., Ph.D., Nursing Consultant; and JAMES WILLIAM TREECE, Jr., B.R.E., B.A., M.A., Assistant Professor of Sociology, Bethel College, Minneapolis, Minn. May, 1973. Approx. 408 pages, 7" x 10", 54 illustrations. About \$9.00.



A New Book! Byrne-Thompson KEY CONCEPTS FOR THE STUDY AND PRACTICE **OF NURSING** 

The threat of illness has a noticeable effect on patients. This new text will give students insight into understanding these changes. The authors present a working model for assessing patient needs and predicting the effects of nursing care - a sound foundation for subsequent nursing courses.

By MARJORIE L. BYRNE, B.S.N., M.S., Lecturer in Nursing, University of California, Los Angeles, Ca.; and LIDA F. THOMPSON, B.S.N., M.S., Associate Professor, School of Nursing, University of Northern Colorado, Greeley, Colo. September, 1972. 101 pages plus FM I-XVI, 6" x 9", 12 illustrations. Price, \$4.15.

# SPIRIT OF '73



THE C. V. MOSSY COMPANY, LTD. 86 NORTHLINE ROAD TORONTO, ONTARIO M4B 3F5



Why not have the "black and white cocktail" served in your hospital in the Patient Cup™? The wide-mouth opening of this liquid unit dose container makes it easy for the patient to drink ORGANON'S smooth suspension of Milk of Magnesia and Cascara. (It's pleasant tasting, too.)

Each Patient Cup delivers a stable, precise dose of Magnesium Hydroxide (8%) equivalent to 30 ml. Milk of Magnesia U.S.P., and Cascara Extract equivalent to 5 ml. Aromatic Cascara Fluid extract U.S.P. Alcohol 3.5%.

No mixing. No pouring. No waste. Here is another opportunity for your pharmacy to extend its control of medication right up to the administration of a single dose. And, you'll make some more friends in the nursing department as well.

Order several shippers of Milk of Magnesia-Cascara Suspension. There are 100 doses in each, packed 10 to the shelf tray.

Set 'em up!



The Patient Cup



#### ORGANON CANADA LTD/LTÉE

INTRA MEDICAL PRODUCTS DIVISION TORONTO, CANADA

## news

CNA Directors Change Eligibility **For CNATS Board And Committees** 

Ottawa — Directors of the Canadian Nurses' Association approved waiver of the requirement for membership in a provincial nurses' association for nurse members of the Canadian Nurses' Association Testing Service (CNATS) poard of directors and committees, on January 11, 1973.

They substituted a requirement that ill nurse members of CNATS board and committees be currently licensed/reg-

stered.

During discussion one director pointed out that the College of Nurses of Ontario, which is responsible for nurse registration and is the jurisdicional body representing Ontario on he testing service, does not require nembership in the Registered Nurses' Association of Ontario. CNA directors said it was inappropriate to impose a requirement of RNAO membership on College representatives to the testing service board and committees.

CNA directors approved recommenlations in the report of Jean Dalziel, hairman of the CNATS board, to implement the transfer of functions from he executive director of CNA to the idministrative officers of the testing ervice. (News, November 1972, page

7.) The directors agreed that the testing

ervice will be free to operate within

he annual CNATS budget approved by he CNA board.

The CNATS directors of test developnent and of administration, who are esponsible to the CNA board, will report to CNA directors through the chairman of the testing service board.

**Canadians On ICN Committees Ready Reports For 1973 Congress** 

Geneva, Switzerland — Canadians are nembers of two committees of the nternational Council of Nurses (ICN), which have completed reports and ecommendations for the ICN Congress n Mexico City, May 13 to 19, 1973.

Lyle Creelman, Bowen Island, B.C., s chairman of the ICN membership committee. This committee will recomnend to the Council of National Representatives (CNR) that six national jurses' associations now in contact vith ICN be admitted into full membership. Provided the CNR accepts the committee's recommendations, these six associations will be formally accepted into membership during the closing ceremony at ICN's 15th quadrennial congress in Mexico City.

Committee members are nurses from Australia, the United States, Nigeria, New Zealand, the United Kingdom,

and Jamaica.

The professional services committee, of which Laura Barr, Toronto, is a member, put the final touches to its proposed revised Code for Nurses. The Code will be presented to the CNR for adoption in Mexico in 1973.

The committee discussed plans for a second international seminar on nursing legislation, tentatively scheduled for April or May 1974 in Latin America. This seminar will be conducted in Spanish. It will focus on the legislative needs of nurses of Latin America, but all ICN member associations will be invited to send a representative, who must be Spanish-speaking.

Chairman of the professional services committee is Ingrid Hämelin, Finland. Committee members, in addition to Ms. Barr, are from Israel, Switzerland, Jamaica, and the United Kingdom.

**CNA In Favor Of ICN Committee** On Library Resources For Nursing

Ottawa — The CNA board at its meeting January 11-12 agreed to support a resolution forwarded to the board president from the Interagency Council on Library Resources for Nursing.

This resolution urged the CNA and

#### **CNA Annual Meeting Dates**

The 1973 annual meeting of the Canadian Nurses' Association will be held in Ottawa, Thursday, April 12. The board of directors will meet on April 11 and 13, 1973.

The CNA directors selected the week beginning Sunday, June 16, for the 1974 annual meeting and convention to be held in Winnipeg,

Manitoba.

The 1976 annual meeting and convention will be held the week of June 20 in Halifax, Nova Scotia.

the American Nurses' Association (both members of the interagency council) to recommend that the International Council of Nurses consider the establishment of a permanent or standing ICN committee on library resources for nursing and provision for a library exhibit and/or program at the 1977

and future congresses.

The personal efforts of Virginia Henderson, research associate and director of nursing studies index program of Yale University's school of nursing, gave impetus to the library program and exhibit at the 1969 ICN Congress in Montreal. It has been learned that there will be a library exhibit and/or program at the ICN Congress in Mexico City, again largely because of Ms. Henderson's enthusi-

International interest in library resources for nursing was demonstrated at the Montreal congress, and the importance of these resources to the advancement of nursing education, practice, and research warrants continuation of such activities on a broader and continuing basis.

#### Pay For Nurse In Expanded Role Should Be Salary, Not Fee: CNA

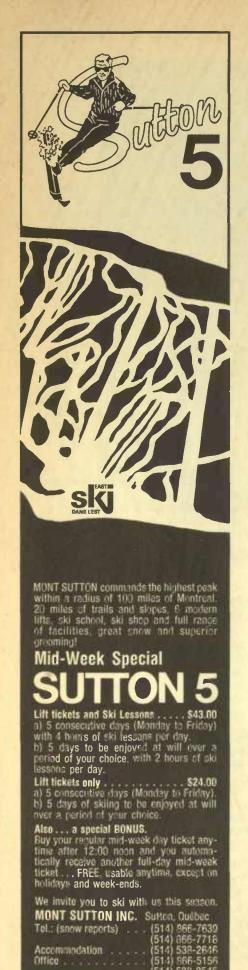
Ottawa — The nurse in an expanded role should be paid a salary, rather than a fee for service. CNA directors approved a position statement on the method of remuneration for the nurse in the expanded role, at their meeting on January 12.

The salary for the nurse in the expanded role should be adequate, competitive, and should include recognition of experience, educational qualifications, responsibility, and seniority. The nurse working in an expanded role should have income security benefits, such as sick leave and pension plan, the CNA statement said.

Nipawin Nurses Challenge Order Of Sask. Labor Relations Board

Regina, Sask. — The Nipawin district staff nurses' association will challenge the order of the labor relations board of January 11, 1973, which found it to be a company-dominated organization and dismissed its application for certification as a bargaining unit.

THE CANADIAN NURSE 11



#### Canadian Nurses' Association

#### 1972-74 Biennium

#### **Priorities**

During this biennium, the priorities set toward meeting the objects of the Corporation have been defined as follows:

1. To define, in collaboration with other disciplines, the scope of nursing practice in a variety of settings, including hospitals, public health agencies, and community health centers.

2. To support provincial associations in seeking legislative changes for nurses

working in an expanding role.

3. To identify and recommend appropriate basic and continuing preparation of nurses through national meetings or conferences on nursing education.

4. To influence changes in the health care system by collaborating with government and with other national organizations whose primary concern is health.

5. To encourage the active participation of CNA members in Association affairs by setting up ways to implement the new committee structure.

6. To inform the general membership of current issues having an impact on nursing by using the library as a center for information exchange, by publishing information in the official journals, and by preparing and distributing working papers on nursing concerns. These working papers would include topics such as continuing education, staff development, and specialization in nursing.

7. To encourage research projects that will identify quality in nursing and

demonstrate the expertise of nursing practitioners.

8. To maintain relationships with international and national organizations

concerned with health, nursing practice, and nursing education.

9. To establish guidelines for providing economic recognition to nurses

practicing in the expanding role.

(See News, January 1973, page 12.)

The decision to test the validity of the board's finding was taken at a weekend meeting of the Nipawin association executive.

The following resolution was passed at that meeting: "That the Nipawin District Staff Nurses' Association launch an application to the Saskatchewan Court of Appeal to quash the decision of the labor relations board dated January 11, 1973, and the association's solicitor be instructed to act accordingly."

The Nipawin association's action has been given the full support of the Saskatchewan Registered Nurses'

Association.

The council of the SRNA, at a special weekend meeting in Saskatoon, agreed that the Saskatchewan Registered Nurses' Association would support the Nipawin association financially and otherwise in its bid to have the board's order quashed by the court of appeal.

D.K. MacPherson, legal counsel for the association, will file within the next week the necessary documents for application to quash the board's order. He will proceed on the ground that the labor relations board did not direct itself to the issue and acted beyond its jurisdiction.

Mr. MacPherson also will ask the labor relations board at its current sittings in Regina to adjourn the 13

pending applications by staff nurses' associations until the Nipawin case has been resolved by the courts.

The Nipawin association's application was opposed by Local 333 of the Service Employees' International Union on the basis that it was organized, formed and influenced in its administration by the SRNA which, the union claimed, is an employer or that members of its elected council are employer's agents.

SEIU has an application before the board for certification as the bargaining agent for all employees at Pineview Lodge in Nipawin, including three registered nurses whom the Nipawin association was seeking to represent, along with registered nurses at Nipawin Union Hospital.

The board previously certified nine staff nurses' associations, none of which

was opposed by a union.

#### AARN Says Nurses' Jobs Available In Alberta

Edmonton, Alta. — The supply of nurses in Alberta is not as adequate as it was one year ago. A comparison of nursing vacancies in active treatment and auxiliary hospitals shows 211 positions open in January 1973, compared to 175 last year.

Seventy-six positions, or 70 percent

(Continued on page 14)

# Here is a new, fast and sterile way to prepare Xylocaine infusions

for life threatening arrhythmias



# **Xylocaine**<sup>®</sup>

(Lidocaine Hydrochloride Injection, Astra Std.)

**One Gram** 

- The special 5 ml transfer syringe contains 200 mg/ml Xylocaine and can be added to infusion set-ups without removing solution from infusion flask or bag
- Cuts preparation time in half
- Easy and convenient to use
- Adds another link to the sterility chain
- Disposable
- Clearly labeled for positive safeguard against error

ASTRA Pharmaceutical Division, Mississauga, Ontario



#### news

(Continued from page 12)

of the total nurse vacancies in the north central area, are in hospitals within the city of Edmonton. For the first time in some years, several hospitals in Calgary are listing vacancies.

The Alberta Association of Registered Nurses (AARN) was concerned about a report that said approximately 200 nurses were drawing unemployment insurance in Edmonton. Further information from the Unemployment Insurance Commission indicates this figure includes all recipients with nursing background - practical nurses, certified nursing aides, and registered psychiatric nurses as well as registered nurses. The figure also includes recipients of maternity benefits.

In the interpretation of the Unemployment Insurance Act, nurses are expected to take advantage of any job opportunity, for which they are qualified, that becomes available in their area. The AARN operates a placement service for members seeking employment.

Neurosurgical Nurses Of World Federate, Plan 1973 Meeting

Montreal, Quebec - A World Federation of Neurosurgical Nurses has been formed, affiliated with the World Federation of Neurosurgical Societies. Secretary of the new international nursing group is Doris McDonald, staff nurse of the neurosurgery department, Charles Le Moyne Hospital. Greenfield Park, Quebec.

The first congress of the new federation will be held in Tokyo, Japan, on October 8 to 10, 1973, at the time of the fifth international congress of

neurological surgery.

President of the federation is Agnes M. Marshall, USA. Other officers are Luta L. Siemens, The Netherlands, vice-president; Jeanne M. Boyd, USA, treasurer; and Berit Malmberg, Finland, editor of publications.

The nurses' executive committee met in Prague, Czechoslovakia, in June 1971 and initiated plans for the Tokyo meeting. In addition to meeting for business, the officers of the nurses' group were invited to present papers on nursing care to the fourth European congress of neurosurgery, held in Prague. Topics discussed included stroke care units and nursing care for patients with anterior fusion for herniated disc in the cervical area.

Membership in the world federation is limited to nurses in the specialty field of neurosurgery as determined by member societies throughout the world. Inquiries about membership in the nurses' federation and attendance at the Tokyo meeting should be addressed to Ms. McDonald at Charles Le Moyne Hospital.

**Executive Director Emphasizes** Student Participation In ICN

Geneva, Switzerland — Adele Herwitz. executive director of the International Council of Nurses, expressed the hope that, at the ICN Congress in Mexico City in May 1973, a unity of thought, purpose, and effort will be created between ICN and student nurses around the world.

In Mexico, student nurses, for the first time, will be full-scale partners in the plenary session panels to debate issues before the nursing profession. (For panel topics, see News, September

1972, p.17.)

The provision of quality health care to individuals everywhere demands closer collaboration among all those involved in the provision of health services, Ms. Herwitz said. "But surely no collaboration is more basic, more important for the future of our profesthan that between today's practitioners and the students who are tomorrow's nurses.'

There is no room in nursing, and in our professional organizations, for a generation gap, Ms. Herwitz said. "We cannot treat student nurses as less than mature and self-directing and, the moment they are graduated, expect that they will become enthusiastic participating members of our professional associations. National associations should capitalize on the contributions students can make to the viability of the association.

"Let's accept our responsibility for promoting students' participation in planning for the future of our profession, in the development of our professional organizations, and in the growth of ICN."

Ont. Transfers Diploma Programs From Hospitals To Colleges

Toronto, Ont. - Early in January 1973, the Ontario government announced that responsibility for nursing education at the diploma level will be transferred from the province's 56 hospital and regional schools to 22 colleges of applied arts and technology. The transfer is set for September 1, 1973.

According to the government, most of the planning for this transfer, affecting close to 10,000 students and more than 1,500 staff members, will be done by local task forces established in each

(Continued on page 18)

# Famous NURSE MATES



#### New Kork Lites Featherweight Style

New "Kork"-Lites Feathe
an extremely lightweight professional
walker, with the new "bottom" look.
Smart, comfortable lace-up heel
oxford over bumper to least. Thick
simulated cork sole with 1½"
cork heel (very slip resistant,
and outwears crepe). Styled
in white washable soft
glove upper leather,
tricotlined, with arch
vents. The very latest
... reflecting trends

(Specify size under COLOR column

#### No. 638 Kork-Lite Shoe . . . 17 00 All-Weather NURSES' CA



for size exchange

Stay sing in cool weather, dry in the Traditional Navy with Bright Red I Finest tailoring of 65% Bacron poly 35% combed cotton. Zepel treated. I Nylon Duralyn linnig. Snap fasteners, openings. Matching head scarf. Was warm water, tumble dry and smooth. S (up to 34 bust), MEDIUM (35-38,) or I (39-42). Specify size on coupon. specify size on coupon COLOR"

No. 658 Cape . . . . . . 14.95 6-11 13.95 ea., 12 or more 12.95 3 Gold Initials inside collar, add 1.00 per

#### Cobbler-Style TUNIC

Pretty and perky over uniform, pants, skirt or dress . . . serves many needs 200 dnr. washable Nylon Taffeta. 29" long, 20" wide. Huge, handy oversized pockets. Choose all snow-white . . . or aqua or red with black trim.

No. 360 Tunic . . . 4.98 ea., 6 or more 4.50 ea. 2 Gold Initials on pocket, add 50¢ per tunic.



#### Vinyl or Dacron APRONS

Vinyl of Uacron APKUNS
Professional extra-heavy duty translucent vinyl apron (left)... (deal for messyjobs anywhere! 36" long, 30" wide.
No. 1200 Vinyl Apron. ... 2.69 ea.
6-11 2.50 ea., 12 or more 2.25 ea.
Dacron apron (right) features scoop neck
bib that folds under out-of-sight if
desired. 3-gored skirt, side pocket, extra
wide hem. Skirt 19" long, 24" wide.
Color white only.
No. 264 Dacron Apron. ... 3.98 ea.
12 or more 3.50 ea.
2 Gold-Stamped Initials en either apron, edd S0¢ per apron.



#### Nurses' POCKET PAL KI

Handlest for busy nurses. Includes white Or Pocket Saver, with S" Bandage Shear (both si opposite page), Tri-Color ball-point pen, handsome little pen light . . . all silver finis Change compartment, key chain. all silver finis

No. 291 Pal Kit . . . . . . 4.95 3 Initials engraved on shears, add 5De per k

#### Endura STOPWATCH

A fine Swiss instrument for critical timing. Records to 1/10 second (2 full revolutions per minute). Anti-magnetic, guaranteed accurate. Numerals red and black on white face. Top bullon starts/stops; side button returns to zero. Grey Cycolac molded case, serrated griptight edge. 18" red neck loop.

No. 15-129-1 Stop Watch . . . 19.95 ea. 3 engraved initials on back, add 1.00 per watch





#### Pull-Out KEY-KEEP!

End fumbling for keys! Pin key-keeper on form or in bag, Attach keys to bead chain, out to use key, rewinds automatically. I convenient. Silver finish. In plastic gift! No. 155 Keeper . 2.49 6-112.25 ea. 12 or more, 2.00 ea 3 initials engraved, add 50s per Kee

#### Brass DOOR NAMEPLATES

Trim, distinctive and helpful for callers. Your Name engraved and lacquered into smart solid brass 2½" doorplate. Satin gold with polished border, weather-proof finish, black lettering. Brass nails

MR. & MRS. OONALD HANSCOM THE HOLBRU

No. 701 Doorplate 1.98 00. Print name desired <u>clearly</u> on seperate paper.



Fast-Action Personalized TOURNIQU Heavy grey rubber strap with Velcro® brand closure, ap and releases instantly. For blood samples, emergen Plastic gift box. 3 initials on back included FREE.

14 THE CANADIAN NURSE

# Name Pins...and Other Nice Things... from Reeves

Reeves Name Pins . . . most popular among nurses! Superb quality, smartly styled, with sharp, clear names deeply engraved.

#### IT'S EASY TO ORDER REEVES NAME PINS FOR YOURSELF OR FRIENDS!

Choose style you want, shown right. Print name (and 2nd line if desired) on dotted lines below. Check other info in boxes on chart, clip this section and attach to coupon

bottom right. Attach extra sheet for additional pins. NOTE SAVINGS ON 2 IDENTICAL PINS . . . more convenient,

PRICES\* Engraved 1 Line | Engraved 2 Lines ☐ Polisher ALL METAL . . . rich, trim and tailored. Lightweight, smooth edges, rounded corners. Gold Gold ☐ 1 Pin 1.98 ☐ 1 Pin 2.5 169 ☐ Satin 2 Pins 3.25 Silver 2 Pins 3.85 PLASTIC LAMINATE . . . slimmer, broader; engraved thru surface to contrasting core color. Beveled border matches lettering. White Black ☐ 1 Pin 1.45 □ 1 Pin Med. Green Med. Blue Cocoa 559 2 Pins 1.65 2 Pins 2.30 METAL FRAMED . . . with sno white plastic center. Smooth beveled edges. Gold Silve ☐ Black ☐ Dk. Blue 100 MOLOED PLASTIC White ☐ Black ☐ Ok. Blue 1 Pin .95 ☐ 1 Pin 1.45 ☐ 2 Pins 2.30 510

\*Please add 25¢ per order for 3 pins or less.

(BCL)

JEWELRY

-------------

31/2" MINI SCISSORS

Tiny, handy, slip into uniform pocket or purse. Choose jewelers Gold or gleeming Chrome plate finish on coupon.

BANDAGE SCISSORS Personalized, precision-made forged Lister scissors. Guaranteed 2 years.

41/2" or 51/2" SCISSORS

Finest sculptured Fisher charms, Sterling or Gold Filled (specity under CDLOR on coupon). For bracelet or pendant chain. Add to your collection!

PIN GUARD Sculptured caduceus, chained to your professional letters, each with pinback! Safety catch, Or replace either with class pin for safety, Gold finish, gift boxed. Choose RN, LPN

POCKET SAVERS
Prevent stains and wear
Smooth, pliable pure white vinyl. Ideal
low-cost group gifts or fevors.

An authentic, unique favor, gift or engraved award! Ceramic off-white candleholder with genuine gold leaf trim. Recessed candle cup (candle nof included). 7" long.

NIGHTINGALE LAMP

No. 3420 Pin Guard . . . . 2.95 ea.

No. 210-E (right), two compartments with flap, gold stamped caduceus . . . 8 for 1.50, 25 or more 20∉ ea.

No. 781 fleft) Deluxe Saver, 3 compt., change pocket & key chain . . . . 6 fer 2.98, 25 or more 35¢ ce.

No. 263 Caduceus; No. 164 Cap; No. 68 Grad, Hat; No. 8. Band. Scissors . . 3.49 ea. 14K PIERCED EARRINGS

Deinty, detailed 14K CALL

As above, but larger for bigger jobs. Chrome finish only. Chouse No. 3500 (3½"), No. 4500 (4½") or No. 5500 (5½") . . . 2.75 ee. 1 Doz er more . . \$2.00 ea. Your initials engraved, add  $50_\sigma$  per scisers.

**NURSES CHARMS** 

Deinty, detailed 14K Gold caduceus, for on or off duty wear. Shown ectual size. Gift boxed for friends, too. No. 13/297 Earrings . . . . . . 5.95 per pair.

QUANTITY DISCOUNTS: 10-24 pins, deduct 10%; 25-99 pins, 15%; 100 or more pins, 20%,



MEDI-CARD SET Handiest reference ever! 6 smooth plastic cards (3½" x 5½") crammed with information, including Equivalencies of Apothecary to Metric to Household Meas, Temp. °C to °F, Prescrip. Abbr., Urinalysis, Body Chem., Liver Tests, Bone Marrow, Disease Incub. Pariods, Adult Wgts., Child's Dosages, etc. All in white vinyl holder with gold stamped caduceus. No. 289 Card Set . . 1.50 es. 6 or more 1.25 ea. 12 or more 1.10 ea. Your initials gold-etamped on holder, add 50s per set.



CAR

KELLY FORCEPS So handy for every nurse! 5½" stainless steel, fully guaranteed. Ideal for clamping off tubing. Your own initials help prevent loss.

No. 25-72 Forceps . . . 2.75 ca. 8 or more 2.50 ca. Your initials ongreved, edd 50¢ per forceps.



### Free Initials and Scope Sack with your own Littmann Nursescope!



No. 216 Nursescope.

Famous Littmann nurses diaphragm stethoscope . . . a fine precision instrument, with high sensitivity for boold pressures, apical pulse rate. Only 2 ozs., fits in pocket, with gray vinyl antipocket, with gray vinyl antip

FREE INITIALS AND SACK! Your initials engraved FREE on chest piece; lend individual distinction and help prevent loss. Also FREE SCOPE SACK included, worth \$1. as described above right. (Free sacks not personalized; add 50½ if initials desired.) Ideal for group gifts! Note big savings on quantity orders (left) ings on quantity orders (left)

\*IMPORTANT NEW FEATURE: New ''Medallion'' styling includes tubing in colors to match metal parts. If desired, please add \$1. ea. to all prices above, and add ''M'' to Order No. (No. 216M) on coupon.

MRS. R. F. JOHNSON SUPERVISOR

Tahored All-Metal No. 169

No. 555

CHARLENE HAYNES

MRS. HOLBROOK ANN COHN, L.P.N.

All White Plastic No. 510

Metai

Framed No. 100



SCOPE SACK neatly carries and protects Nursescope or any scope. Double-thick frosted flexible plastic, white vinyl binding. 4½" x 9½". Your own initials help prevent loss. No. 223 Sack... 1.00 ea. 9 or more 75¢ ee. Your initials gold-stamped, edd 50¢ par sack.

#### **NURSES PERSONALIZED** ANEROID SPHYG.

A superb instrument especially designed for nurses! Imported from precision craftsmen in W. Germany. Easy-to-attach Veloro cuff. lightweight, compact, fits into soft sim. leather zippered case 2½" x 4" x 7". Olal calibrated to 320 mm., 10-year accuracy guaranteed to 2-3 mm. Serviced by Reves if ever required. Your initials engraved on manameter and gold stamped on case FRE, for permanent identification and distinction. A wise investment for a lifetime of dependable service! superb instrument especially No. 106 Sphyg. . . . 29.95 ea.



#### CAP ACCESSORIES

(NAI) CAP TOTE keeps your caps crisp and clean while stored or carried. Flexible clear plastic, white trim, zipper, carrying strap, hang loop. Stores flat. Also for wiglets, curlers, etc. 8½" dia., 6" high.

No. 333 Tote . . 2.65 ca., 6 or more . . 2.35 ca. Your initials gold-stamped, add 50, per Tote.



WHITE CAP CLIPS Firmly in placel Hard-to-find white bobbie pins, enamel on fine spring steel. Eight 2" and eight 3" clips included in plastic snap box. No. 529 Clips . . 3 boxes for 1.95, 6 for 3.25, 12 for 49¢ ea.

MOLDED CAP TACS

Replace cap band instantly. Tiny plastic tac, dainty caduceus. Choose Black, Blue, White or Crystal with Gold Caduceus; or ell Black (plain). The neater way to fasten bands. No. 200 Set of 6 Tacs . . . 1.25 per set. 12 or more sets 1.00 per set



ALL METAL CAP TACS Dainty, jew-elry-quality Cap Tacs with grippers to hold cap band securely in place. Sculptured metal Caduceus, poished gold finish, clutch fastener. Two Tacs per set, gift boxed. Ideal Class favor or group gift. Add a bit of style to your cap! No. CT-2 Cad. Tacs . . . . . . 2.50 ea.

SEL-FIX CAP BAND Black velvet band material. Self-adhesive, presses on pulls off; no sewing or pinning. Reusable several times. Each band 20" long, pre-cut to popular widths: 4x" (12 per plastic box) 4x" (8 per box) 4x" (8 per box) 4x" (8 per box). Specify width under ITEM column on caupen. No. 6." 5x or 5x per 1x p

aper. It is now available from CNA for \$1. on the professional association's roles will

of nursing education: The ad hoc commitat the September 1972 board meeting to dea of a national nursing education confernended that the conference be held in the NA directors accepted the recommendation planning committee to continue its work. participants will be invited from nursing d nursing service. The conference will cum for nursing leaders to discuss the of nurses for future roles, such as the

THE CANADIAN NURSE

EXAMINING PENLIGHT CDM White barrel with caduceus imprint, aluminum band and clip. 5" long, U.S. made, batteries included treplacement batteries available any store). Your own light, gift boxed. Na. 007 Panight . . . 3.98 ma. Your Initials ongraved, edd 50¢ por light. CROSS PEN Natalie B. Harens

No. F100S Lamp . . 8.95 ea., 12 or more 4.95 sa. Initials and date engraved on gold plaque . . . add 1.00 per lamp. NURSES WATCHES Hamilton 17 Jewel "Buren" Calendar Watch, 17 jewels, sweep-second hand. Date changes at midnight. Water, shock resis., anti-meg., unbreek. mainspring. Chromo finish, expan. bracelet, 1 yr. guarantee. No. BL53 Ham. Watch . . . 34.95 ea. Endura Waterproof Swiss made, reised silver full numerals, lumin. markings. Red-tipped sweep second-nand, chrome/stainless case. Includes genuine black reather watch strap. I year guarantee. Very dependable. No. 1093 Endura Watch .

MCA 6-8-70

BZZZ MEMO-TIMER Time hot packs, heat lamps, park meters. Remember to check vital signs, give medication, etc. Lightweight, compact (£½" dia.), sets to buzz 5 to 60 min. Key ring. Swiss made.

No. M-22 Timer . . . . 3.98 es. 3 for 9.75 , 6 or more 3.00 es.

CROSS PEN
World-famous ballpoint, with
sculptured caduceus emblem. Full name
FREE engraved on barrel (include name with coupon).
Refilis avail. everywhere. Lifetime guarantee.
No. 3502 Chrome 8.00 ea. No. 6602 12kt, G.F. 11.50 es.

# **NURSES HAVE A SPECIAL** JOB TO DO. TYCOS HAS A SPECIAL **SCOPE TO DO IT.**

Because your job is different, you need different equipment. That's why we've engineered our nurse's stethoscope for your needs. From binaural to diaphragm, length to looks, it's a better instrument. Check these special features, then check your Tycos medical dealer.



Taylor Instrument Companies of Canada Ltd., 75 Tycos Drive, Toronto, Ontario. M6B 1W4

Special mushroom-shaped, soft neoprene rotating eartips. Let the 'scope swing as your head moves, get rid of that binding feeling. And the sound-seal remains unbroken, too.

Special lightweight binaural. As rugged as the regular one, but better to carry around

When it comes to moving about, we've made the tube longer. A full 21-inches. (Scope length — 291/2"). Yet, because of our tapered tube design, you don't lose sound.

treasurci,

Finland, editor or prow your own 'scare (as well as for

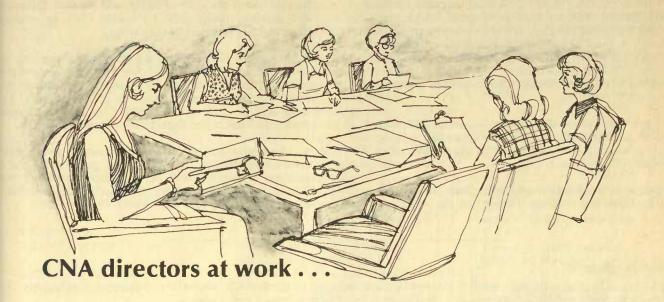
The nurses' executive committee met in Prague, Czechoslovakia, in June 1971 and initiated plans for the Tokyo meeting. In addition to meeting for business, the officers of the nurses' group were invited to present papers on nursing care to the fourth European congress of neurosurgery, held in Prague. Topics discussed included stroke care units and nursing care for patients with anterior fusion for herniated disc in the cervical area.

Membership in the world federation is limited to nurses in the specialty field of neurosurgery as determined by

he tube Liquat egreen

The low-profile chest piece as well as being lighter weight, can easily be removed from the tube for replacement. And, to improve your patient popularity, it has a non-chill, snap-on diaphram.

See and try out the new Tycos® Vurse Stethoscope at your dealer.



#### A capsule account of some issues being examined by the Canadian Nurses' Association's board of directors.

- Accreditation of programs in nursing education: To help directors make a decision on a national system of accreditation for nursing education, a group representing nursing and general education has been appointed. They will explore alternative methods of ensuring quality of nursing education programs; determine criteria and methodology, cost, and human and material requirements of a national accreditation scheme of nursing education; and submit a report to CNA directors.
- Response to the community health center project (Hastings Report): At their January meeting, directors accepted a response prepared by Rose Imai, former CNA research officer, as a basis for development of a CNA position on the Hastings Report. Several directors said CNA should present strong, succinct, positive statements. The CNA position paper was prepared by CNA staff after the January board meeting, and circulated to directors for comments that were incorporated into the final response. The CNA reaction was delivered to the department of national health and welfare before the end of February.
- CNA second vice-president: Directors decided not to fill the position of second vice-president for the remainder of the term.
- Specialization in nursing: The paper reporting analysis of responses from 125 individuals and groups to the questions in "Specialization in nursing — where? when? how?" (May 1972, page 39) was accepted by directors. It was published by CNA as a discussion paper, and is

- now available for \$1 from CNA House. CNA staff will develop a position for directors' approval, using the nurse who analyzed the responses, as a consultant.
- Policy and action on smoking: Consideration of the proposed policy and action on smoking was postponed until the directors meet in April.
- Revision of rules and regulations: Directors approved the revised rules and regulations for CNA, including guidelines for temporary committees. A booklet of CNA bylaws, letters patent, and rules and regulations is now available free to CNA members.
- Study of three major roles of a professional association: Directors accepted the amended report on the roles of a professional organization, for publication as a discussion paper. It is now available from CNA for \$1. A statement on the professional association's roles will be considered at the board meeting in April.
- Objectives of nursing education: The ad hoc committce, set up at the September 1972 board meeting to explore the idea of a national nursing education conference, recommended that the conference be held in the fall, 1973. CNA directors accepted the recommendation and asked the planning committee to continue its work. Conference participants will be invited from nursing education and nursing service. The conference will provide a forum for nursing leaders to discuss the preparation of nurses for future roles, such as the primary care nurse.

#### news

- Brief from Health Action '72: A brief prepared by the liaison committee of the Canadian Medical Association, CNA, and Canadian Hospital Association, as a result of the Health Action '72 conference, was sent to the minister of national health and welfare and to the provincial ministers of health in December 1972. Health Action '72 was the first joint meeting of the boards of directors of CMA, CNA, and CHA.
- CNA journals sent to developing countries: Directors agreed to continue sending the two Canadian nursing journals to nursing schools and health agencies in more than 80 developing countries.
- Response to final report of the LeDain commission on non-medical use of drugs: Officers of the provincial

nursing associations will submit the names of individuals who have the knowledge and experience to review the final report of the LeDain commission when it comes out. CNA staff will prepare a statement from their responses; if the proposed statement is not in violation of CNA policy and is approved by a CNA officer, it can be sent to the minister of health and welfare. Directors are seeking mechanisms to enable CNA to respond more quickly to issues as they arise.

- Guidelines for numbers of nurses and nursing assistants required in the next five years: CNA agreed to establish guidelines for the numbers of nurses and nursing assistants required in the next five years. The work will be done under contract for the health manpower division of the department of national health.
- CNA policy statements: A collection of policy statements made by CNA in briefs to the government and as position statements will be published, replacing "On Record." Directors believe this method of publication can be kept up-to-date more easily.

(Continued from page 14)

college area. These groups will work out the curriculum, admission procedures, clinical arrangements with participating hospitals, and other matters.

The nursing schools' academic facilities will continue to be used for nursing education programs; residence facilities may be used for these programs or for health care programs for the public.

The College of Nurses of Ontario will inspect the college programs and students will continue to write the standard examinations for registration at the end of their program.

In an interview in Ottawa with *The Canadian Nurse* following the government announcement, Dr. Josephine Flaherty, president of the Registered Nurses' Association of Ontario, said: "RNAO has gone on record as favoring placement of nursing education in general education. We have been discussing and working with the government for some time on this issue and nine months ago we discussed this with the minister of colleges and universities. We agreed it would be an orderly transition and that we would be involved in it.

"Since that time, all our attempts to discuss the matter further have been met with the response that matters of a negotiable nature could not be discussed until government decisions had been made. The announcement was a surprise to us at this time.

"We are very concerned that continuity and stability of education programs for students who are enrolled at the moment be retained. We are concerned that staff members who move to the college system with the programs will not be disadvantaged by the move."

In Toronto, Dr. Flaherty spoke out against the Ontario Hospital Association's efforts to have hospital schools of nursing become affiliates of community colleges, rather than being fully integrated into the colleges, to retain their schools' identities. She said, "I cannot agree that our province should support a parallel system of post-

#### Wanted: Student Uniforms

Ontario's hospital and regional nursing schools will move into community colleges in September 1973 (News, page 14); Quebec and other provinces have already made the move into general education.

The archives at CNA House provides facilities for preserving the history of nursing schools and making it available to researchers on a national basis. Several schools of nursing have given student uniforms to the archives collection.

A complete uniform collection from a school might include typical student uniforms from the past; a modern, student uniform; caps; pins; dates of the uniforms; photos showing how the uniforms were worn; and information on shoes and stockings worn with the uniforms. A history of the school of nursing is useful.

Schools of nursing that wish to deposit student uniforms in the CNA Archives may contact Margaret Parkin, Librarian, CNA House, 50 The Driveway, Ottawa, Ontario, K2P 1E2.

secondary education exclusively for nurses."

Dr. Flaherty also replied to OHA spokesman Peter Wood, who was reported as saying evidence has shown that nurses training away from hospitals have trouble adapting to hospital jobs. The RNAO president noted that the only Canadian study on this subject was the report of the first five years of the nursing program at Ryerson Polytechnical Institute; it said the graduates were well regarded by their hospital employers.

In opposing the OHA stand, Dr. Flaherty emphasized that nursing education must have a larger scope than just hospitals. "There are serious implications for Ontario if health workers continue to be prepared without acknowledgement of the forward-looking planning for education and for health services, which is basic to the policy decisions of our government."

New Tropical Medicine Group Invites Nurses' Membership

Ottawa — Nurses are invited to join an association, formed in December 1972, of health professionals interested in tropical diseases. The new association will seek approval to be constituted as a division of the Canadian Public Health Association in April 1973, at the next meeting of the CPHA council.

"Nurses are particularly welcome to join," Dr. Richard Roberts, interim secretary-treasurer of the new association, told *The Canadian Nurse*. The organization will be called the tropical medicine and international health division of the CPHA.

"The group is interested in hygiene in the broadest sense. We want to

18 THE CANADIAN NURSE

## Next Month in

## The Canadian Nurse

- Freedom —
   An Outmoded Tradition
- Laparoscopy for Tubal Ligation
- Changing Practice Through Education
- Auscultation of Chest



Photo credits for March 1973

Miller Services Ltd., Toronto, Cover I, p.30

The Children's Hospital of Winnipeg, Winnipeg, Man., p.27

Marko Studio, Thunder Bay, Ont., p.40

Photo Features, Ottawa, pp.46,48

#### news

prevent diseases from becoming a problem," Dr. Roberts said.

It is anticipated that the tropical medicine group will be open to all members of the CPHA for a divisional

membership fee.

Nurses interested in tropical medicine, who might want to join the division, are asked to write to Surgeon Commodore Roberts, National Defense Medical Center, Alta Vista Drive, Ottawa, Ont. K1A 0K6. Dr. Roberts belives it would support the request of the tropical medicine group to the CPHA council if he were able to indicate that nurses were interested in it.

## Red Cross Bursary Available To Ontario Nurses

Toronto, Ont. — A \$1,000 bursary is available to graduate nurses registered in Ontario. The award is offered by the volunteer nursing committee of The Canadian Red Cross Society, to enable an Ontario nurse to take nursing studies at a degree level.

The successful candidate will be selected for her training, nursing experience, leadership qualities, and her anticipated contribution to nursing in

Ontario

Application forms and further information are available from The Canadian Red Cross Society, attention: Ms. E. Mitchell, 460 Jarvis Street, Toronto, Ont., M4Y 2H5. Applications must be submitted before April1, 1973.

Elizabeth Holder, winner of the 1972 bursary, is studying for an M.Sc. in nursing at the U of Toronto.

## Bill Of Rights For Patients To Be Established In N.S.

Halifax, N.S. — Representatives of the Registered Nurses' Association of Nova Scotia (RNANS), doctors, health administrators, and consumers recently named a small committee to draw up a "Bill of Rights" for patients in the province. The committee's draft will be sent to the health associations for approval and then released to the public of Nova Scotia.

The group believes that in this way the consumer of health services will know exactly where he stands and what his rights are.

The decision on the patients' bill of rights was the first of four steps in a plan to improve communications between the patient and his family, and members of the health team.

The meeting of health professionals

Look for these new publications

#### COLLIER-MACMILLAN

Canada, Ltd.

at the R.N.A.O. Convention in May

New Directions in Patient Centered Nursing: Guidelines for Systems of Service, Education and Research.

Abdellah, Beland, Martin, Matheney
02.300050.3 \$13.75 \_\_\_

Psychiatric Nursing (Nurses' Aids Series)

Altschul 7020.0458.8 \$ 3.75 \_\_\_\_\_

7020.0484.7 \$ 5.50 \_\_\_\_

Anatomy and Physiology for Nurses, 8th ed. (Nurses' Aids Series) Armstrong and Jackson

> 7020.0436.7 \$ 3.75 \_\_\_\_ 7020.0437.5 \$ 5.50 \_\_\_\_

Cardiovascular Disorders (Patient Care)
Ashworth and Rose 7020.0420.0 \$ 7.95

Bailliere's Medical Transparencies
Sets 1-8

Thoracic Surgical Management Belcher and Sturridge

7020.0402.2 \$ 7.95

Venereal Diseases: Treatment and Nursing
Elliott and Ryz 7020.0389.1 \$ 6.50 \_

Arithmetic Review and Drug Therapy for Practical/Vocational Nurses, 3rd Ed.

Fitch and Larson 02.338030.6 \$ 5.25

Ear, Nose and Throat Nursing (Nurses' Aid Series)

Marshall and Oxlade 7020.0433.2 \$ 3.75 \_\_\_\_ 7020.0440.5 \$ 5.50 \_\_\_

Fundamentals of Normal Nutrition, 2nd Ed.
Robinson 02.402410.4 \$ 9.50

Chemistry for the Health Sciences, 2nd Ed. Sackheim and Schultz

02.405060.1 \$ 9.50 \_\_\_\_

Microbiology and Human Disease Wistreich and Lechtman

02.479080.X \$13.50

Laboratory Exercises for Microbiology, Rev. Ed. Wistreich and Lechtman

02.479110.5 \$ 5.50 \_\_\_

TOTALS

Please send me the books indicated above.

I enclose my Cheque or Money
Order for \$ \_\_\_\_\_\_\_to
cover the cost of the book(s).

We pay all shipping charges.

Mail to: Collier-Macmillan Canada, Ltd.
1125 Leslie Street
Don Mills, Ontario
Attn. Mrs. Wagschal

Ivallie	
Address	AT HER MANAGEMENT AND ADDRESS OF THE PARTY O

City \_\_\_\_

Province \_\_\_\_\_



#### Tucks\*

offer prompt, temporary relief from the discomforts of itching, burning and irritation associated with hemorrhoids, post-operative anorectal surgery wounds and episiotomies. Used as a compress, they relieve itching and edema with a cooling, mildly astringent action. As an after stool wipe, Tucks gently and thoroughly cleanse while soothing tender, traumatized tissues. Moist, soothing Tucks are soft disposable flannel pads saturated with Witch Hazel (hamamelis water) 50%, Glycerine, U.S.P., 10%, Purilied Water, U.S.P., de-ionized, q.s. buffered to approximate pH of 4.6: They come in jars of 40 pads. Ready prepared Tucks can be kept by the patient's bedside for immediate application whenever their soothing, healing properties are indicated.

#### Fuller Shield\*

Protective dressing to hold anal, perianal and sacral dressing comfortably in place; prevent soiling of clothing or linens with wound drainage, watery fecal leakage, staining medications. Does not bind. No tape needed. Fits male or female patients, waist sizes 24 to 48. Order two per patient; one to launder while other is worn.

For clinical trial supply write to:



## ICN CANADA Ltée

675 Montée de Liesse, Montreal 377, P.Q.

\*Trade marks of Fuller Laboratories, Inc.

#### news

was held at RNANS headquarters and chaired by Margaret Bradley, RNANS president. Meeting with the RNANS executive committee were representatives of the medical society of Nova Scotia, the provincial medical board, the N.S. public health association, and the N.S. hospital association.

## Nurse With Cast On Leg Can't Work Arbitration Board Rules

Toronto, Ontario — A nurse in London Ontario, refused permission to return to work in an intensive care unit because of a cast on her leg, lost her case after taking a grievance to arbitration.

The results of the arbitration board hearing were reported in the November 1972 newsletter from the employment relations department of the Registered Nurses' Association of Ontario.

According to the RNAO report, the nurse was wearing a light cast, extending from the middle of the thigh to just above the ankle. The hospital nurses' association had statements from several orthopedic surgeons at the hospital, which said the nurse was able to work and presented no danger of infection.

However, at the arbitration hearing, only the hospital management had a doctor as a witness. The hospital's health services doctor testified that when a person wears a plaster of paris cast, it is impossible to control infection.

According to the arbitration board report, the doctor said: "Such a cast is not changed and the skin beneath it cannot be kept clean. Even though there was no wound under the cast, the danger of carrying bacterial infection was nevertheless present... Various antiseptic procedures could reduce the risk of bacteria spreading, but for a nurse to carry out these procedures, as frequently as she would have to, while on duty would not be practical."

The three-man arbitration board concluded, "The determination... by the hospital was made on appropriate grounds and does not appear to have been patently unreasonable."

Summing up the board's conclusion, the RNAO newsletter points out the importance of having expert medical testimony, regardless of whether you agree with its accuracy. It adds that a written statement "does not carry the same significance with an arbitration board" as a witness.

# Marlow is back:

Textbook of Pediatric Nursing—the book that has been used by half a million nursing students—is now back in a New Fourth Edition. Now published in an easy-to-use format with large legible type, this latest edition has been completely revised and rewritten to reflect up-to-date concepts and methods in the care of children. It remains unexcelled in its comprehensive coverage of growth and development and nursing care needs of the sick and well child from birth through adolescence. Special attention has been given to genetics, current advances in patient care, government programs, research in fetology, ambulatory and home care, parenteral fluids, kwashiorkor, cystic fibrosis, scoliosis and more. Newly considered topics include: the dysmature infant, pediatric nurse practitioners, hyperalimentation, acute epiglottis, adolescent gynecological problems, Tay-Sachs and sickle cell diseases, contact dermatitis, to name only a few.

By Dorothy R. Marlow, R.N., Ed.D., Dean and Professor of Pediatric Nursing, College of Nursing, Villanova University. 784 pages. 215 figures. About \$9.80. Ready April. Order no. 6098.

## OTHER CURRENT SAUNDERS TITLES

Saunders Major Problems in Clinical Nursing

Spencer: Patient Care in Endocrine Problems
Reviews physiology and pathophysiology of each endocrine organ, along with treatment and nursing care for disease.
Case study given for each disease entity. By Roberta T. Spencer, R.N., M.S. 230 pp. Illustd.\$10.05. Jan. 1973. Order no. 8517.

Sanderson: The Cardiac Patient

A Comprehensive Approach

For both surgical and non-surgical patients. Discusses background of problems, then methods of treatment: electrocardiography, cardiac drugs, cardiopulmonary resuscitation, etc. Edited by Richard G. Sanderson, M.D. 7 contributors. 548 pp. 188 ill. \$11.85. June 1972. Order no. 7905.

#### Robinson:

Psychiatric Nursing as a Human Experience

Establishing a one-to-one relationship with the patient. Discusses anxiety as a dynamic construct, contemporary mental problems, institutional and community health nursing. By Lisa Robinson, R.N., Ph.D. 352 pp. \$8.25. Sept. 1972. Order no. 7620.

# Jacob & Francone: Structure and Function in Man Second Edition

This beautifully illustrated text offers a sound basic knowledge of the organization and workings of the human body. Audio-visual teaching aids and laboratory manual available. By Stanley W. Jacob, M.D. and Clarice A. Francone, Medical Illustrator. Text: 581 pp. 451 illus. over 150 in color. \$9.05. Order no. 5096. Filmstrips: set of 10 with records and scripts. \$180.25. Individual tilmstrips \$18.05. Order no. 9819. Lab Manual: 253 pp. Illustd. Soft Cover. \$4.90. April 1970. Order no. 5101.

## The Nursing Clinics of North America March 1973

This month's issue focuses on two topics. In the first symposium, entitled *The Young Adult in Today's World*, ten experts all from the Haight-Ashbury Medical Clinic discuss such timely topics as: drug abuse, heroin addiction, V.D., war injuries, pregnancy and counterculture and more. Guest editor is *Ruth P. Fleshman*. The second symposium entitled *Current Surgical Nursing* contains articles on surgical procedures most requested by readers. Av. 175 pp. per issue. \$13 per year.

W. B. SAUNDERS COMPANY CANADA, LTD. 833 Oxford Street, Toronto 18, Ontario	
Please send and  bill me send postpaid—check enclosed:    6098	
NameAddress	21 31 11
Prov	CN 3-73



CANADA PHARMACAL CO. LTD., Toronto, Ontario.

**DEMONSTRATION** AND FOLDERS **UPON REQUEST** 

### **Financial Statement**

#### CANADIAN NURSES' ASSOCIATION

#### STATEMENT OF REVENUE AND EXPENDITURE AND SURPLUS

Year Ended December 31, 1972 (with comparative figures for year ended December 31, 1971)

Revenue:	1972	1971
Membership fees	\$ 789,620	\$ 760,866
Subscriptions	42,310	38,732
Advertising	256,943	239,996
Sundry revenue		
	1,101,105	7,637
Expenditure	1,101,103	_1,047,231
Operating expenses:		
Salaries	404 490	417 420
Printing and publications	494,480	417,439
Design and graphics	210,136	210,089
Design and graphics	12,649	8,909
Postage on journal	117,703	110,752
Computer service	20,861	17,376
Committee meetings		34,579
Translation services	2,663	1,063
Commission on advertising sales		20,992
I.C.N. affiliation	37,156	33,986
Consultant fees	9,339	9,943
Staff travel		14,289
Office expense		22,020
Books and periodicals	7,068	7,078
Legal and audit		7,052
Building services		70,080
Sundry	4.035	2,760
Production of film and readership survey	***************************************	11,098
Furniture and fixtures	5,344	13,370
Landscaping and improvements		5,785
Depreciation - C.N.A. House.	31,867	31,867
	1,119,210	1,050,527
The state of the s		
Non-operating expenses:		
1972 convention	3,103	1,430
Canadian Nurses' Foundation	5,488	,
	8.591	<u>5,163</u> 6,593
THE RESIDENCE OF THE PERSON OF	1,127,801	1,057,120
Excess of revenue over expenditure (expenditure	1,127,001	1,037,120
over revenue) before items below.	(26,696)	(0.000)
add:	(20,090)	(9,889)
Excess of revenue over expenditure - C.N.A.		
Testing Service - per statement	01715	54.000
Investment income.		54,020
		29,927
Excess of revenue over expenditure for year	124,511	83,947
Surplus at beginning of year	97,815	74,058
Surplus at beginning of year	<u>776,212</u>	702,154
Surplus at end of year	¢ 974 027	77/ 012
	<u>\$ 874,027</u>	776,212
Market Control of the		

#### **CANADIAN NURSES' ASSOCIATION BALANCE SHEET**

as at December 31, 1972

(with comparable figures at December 31, 1971)

#### **ASSETS**

	1972	1971
Current Assets		
Cash in bank — current account	\$ 83,314	\$ 96,664
— savings account	103,579	140,871
Short term deposits plus accrued interest	566,538	359,705
Accounts receivable	30,288	15,659
Membership fees receivable	14,770	9,794
Prepaid expenses	9,537	10,317
	808,026	633,010
Trust Assets		
Cash in bank	14,000	
Sundry Assets		
Marketable securities - at cost (quoted		
value \$16,453; 1971 \$13,794)	3,779	3,779
Loans to member nurses	6,714	15,135
	10,493	18,914
Fixed Assets		
C.N.A. House - land and building - at cost		
less accumulated depreciation on building	583,657	615,534
Furniture and fixtures - at nominal value	1	1 (15.505
	583,668	615,535
	\$1,416,187	\$1,267,459

Approved on behalf of the Board:

MISS MARGUERITE SCHUMACHER

DR. HELEN K. MUSSALLEM

President

Executive Director

# CANADIAN NURSES' ASSOCIATION

# **BALANCE SHEET**

as at December 31, 1972

(with comparable figures at December 31, 1971)

# LIABILITIES AND SURPLUS

The state of the s	1972	1971
Current Liabilities		
Accounts payable and accrued liabilities	\$ 37,236	\$24,346
Deferred subscription revenue	29,706	27,300
	79,800	<u>41,600</u> 93,246
Trust Liability	110,712	
Owing to Commonwealth Carribean Regional		
Nursing Body	14,000	
Mortage Payable — 63/4 % due 1976 — payable in monthly instalments of \$3,548 to include		
principal and interest	381,418	398,001
Surplus	874,027	776,212
	\$1,416,187	\$1,267,459

We have examined the balance sheet of Canadian Nurses' Association as at December 31, 1972 and the statement of income and surplus for the year then ended. Our examination included a general review of the accounting procedures and such tests of accounting records and other supporting evidence as we considered necessary in the circumstances.

In our opinion, these financial statements present fairly the financial position of the Association as at December 31, 1972 and the results of its operations for the year then ended, in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

> GEO. A. WELCH & COMPANY, OTTAWA, CHARTERED ACCOUNTANTS.

January 10, 1973.

# CANADIAN NURSES' ASSOCIATION STATEMENT OF REVENUE AND EXPENDITURE C.N.A. TESTING SERVICE

Year Ended December 31, 1972

(with comparative figures for year ended December 31, 1971)

Parama	1972	1971
Revenue:		
Examination fees	\$ 318,498	\$ 263,762
Sale of computer program		
	320,576	263,762
Expenditure:		
Salaries	96,192	76,552
Board and committee meetings	24,662	32,507
Item writing	27,801	1,672
Operations (data processing, printing,		
warehousing)	64,034	67,317
Systems design and programming		2,000
Consultants	-	8,454
Rent	7,525	7,525
Translation	4,430	3,021
Office supplies and stationery	3,364	2,988
Postage and express	1,134	2,477
Telephone and telegraph	2,584	1,928
Staff travel	1,385	387
Books and periodicals	268	716
Furniture and fixtures	2,169	1,405
Moving expenses	-	774
Miscellaneous	283	
	235,831	209,742
	¢ 04745	\$ 54,020
Excess of revenue over expenditure for year	\$ 84,745	\$ 54,020

26 THE CANADIAN NURSE MARCH 1973

# Whose baby is this?

The author, head nurse of a 16-bed unit specializing in the care of sick newborn and premature infants, looks at how these patients can be helped when their parents' rights and needs are taken into account by the hospital nursing staff.

# **Lesley Baizley**

In this age of consumer rights and protection, it is pertinent that we, the nursing staffs of hospital nurseries, examine our philosophies and policies and ask ourselves whether the service we are providing is what the consumer — in this case the parent — really wants and needs.

We must ask: What are the rights of parents whose babies are patients in our nurseries? What are our responsibilities to parents? What do our unit objectives state about the service we wish to give parents?

At the Children's Hospital of Winnipeg, we believe parents have the right to be with their babies whenever they wish, restricted only by an immediate medical emergency. Parents also have the right to receive complete information about their babies' health, daily progress, medical treatment, and nursing care.

Ms. Baizley, a graduate of The Children's Hospital of Winnipeg school of nursing, is head nurse of the neonatal intensive care unit at the hospital.

How can nurses ensure that parents' rights are not denied? Possibly we should examine our priorities and ask ourselves, "Whose baby is this?" Some nurses become so possessive about the babies in their care that parents feel they must ask the nurse's permission to do for their baby what is their God-given right.

What are our reasons for barring parents from hospital nurseries? The most common excuse seems to be fear of infection. Is a parent likely to be any dirtier than the nurses, doctors, technicians, and other hospital personnel who enter the nursery each day? Is there any reason parents cannot take the same precautions of handwashing and gowning? I think not.

Another favorite excuse for barring parents is a shortage of staff. We have found it a great help to have several mothers bathe and feed their babies during busy periods; it can also provide an ideal teaching opportunity, even if the nurse is caring for another baby at the time.

Institutional policy and medical

staff resistance are often stated as reasons for barring patients from hospital nurseries. If this is the case, it is time nurses, who pay lip service to clichés such as "emotional support" and "family-centered care," took the initiative in changing the attitudes of administrators and physicians on this vital subject.

Many nurses fear parents will have difficulty adjusting to the death of an infant to whom they have "become too attached." Studies indicate grief reactions of parents are much less pathologic if they have had contact with the baby, as it is difficult to grieve appropriately for someone never known. Many parents express concern that their baby may die without their having had a chance to love him.1

What are we really afraid of? Are we afraid of having outsiders invade our sacrosanct domains? Are we afraid of being unable to answer parents' questions or deal with their emotions

or our own?

The mature neonatal nurse strives to understand parents' reactions and realize that feelings of fear, guilt, frustration, and helplessness often result in hostile and hypercritical behavior. She encourages parents to verbalize their feelings and helps them cope with these feelings.

# Physical contact, information

Studies conducted in neonatal centers have shown the importance of early and continued mother-baby contact, particularly in the case of an ill or preterm baby where prolonged hospitalization is inevitable.<sup>2</sup>

A striking example of this was the case of Barry, a three-week-old infant admitted because of a congenital heart defect. During the first three weeks

of his life, the only contact Barry's mother had with him was through a nursery window and incubator wall. When he was admitted, I asked her if she would like to put on a gown and hold him. A few minutes later, I found her upset and crying. She told me, "I can't love him the way I did the other two. I don't feel that he's mine."

We can help mothers overcome feelings of helplessness and inadequaey by encouraging frequent physical contact with their babies from the time of admission. The mother's relationship with her baby will seem more normal to her if she is encouraged to bathe, diaper, cuddle, and feed him whenever possible, or at least is made aware of the importance of handling him in his incubator if this is all his condition permits.

Most fathers are anxious to cuddle their babies, but are often embarrassed to suggest it. The father may be the only parent available to the baby the first few days, and is proud to be the first to hold or feed his baby. It comforts the mother that he has been encouraged to do so, can describe the baby to her, and report on his progress. Parents need to feel they are doing something for their baby, even if it is bringing a small thing. Nursing staff should try to find out the baby's name and use it when referring to the baby.

By creating an informal atmosphere in the nursery and treating parents and their babies as individuals, we can build a relationship that will strengthen the parents' trust in us. We must take time to answer their questions and often reinforce the physician's teachings and explanations. We must be prepared to give daily and even hourly progress reports. With the exception of predictions or prognoses, which should remain the physician's responsibility, nurses must be able to give parents meaningful and honest explanations and progress reports.

To provide continuity of information, we have kept a written record of all communications with parents, including information from physicians about what parents have been told. A printed sheet outlining services available, telephone and visiting policies, and other general information about the nursery has also been useful.

# Value of a mother's love

Over a year ago, we had two patients, Bobby and Cindy, who had severe congenital heart defects requiring palliative surgery and medical management until corrective surgery could be performed.

Both babies provided tremendous nursing problems with regard to feeding, fatigue, vomiting, and weight gain. We tried many different feeding methods and schedules over a threemonth period. Finally, after observing that both babies were much less anxious during their mothers' visits twice daily, we obtained their physician's permission for trial discharge periods.

These babies went home with their parents and each family was assigned a nurse who maintained daily telephone contact and made home visits. Both mothers were taught and supervised at home in the use of nasogastric gavage for supplemental feeding.

Except for one 12-hour readmission for Bobby, both babies remained at home. Their mothers devised methods and schedules for feeding far more successful than any we had used. Cindy's mother fed her formula and

solids with a spoon, and Bobby's mother dripped formula into the side of his mouth with a syringe and feeding tube while he sucked his thumb.

Follow-up after discharge, either by home visits or telephone calls, can help the hospital nurse realize the problems parents face after discharge. In the case of Bobby and Cindy, it helped the nurse learn adaptations to hospital methods that could benefit other parents with similar problems.

# Parents' views

To evaluate consumer satisfaction, we devised a questionnaire for parents to get their views on nursing care, treatment they as parents received, and their general comments on their babies' hospitalization. I have summarized the most common reactions received on the questionnaire and during personal interviews.

Many parents, particularly mothers who were registered nurses, expressed surprise at being allowed to visit the nursery as often and as long as they wished. They found this flexibility suitable with regard to their other responsibilities.

Most parents expressed an initial fear of handling their babies and appreciated the opportunity to become accustomed to this gradually during hospitalization. They felt much more secure after bath and care demonstrations, help with feeding problems, and repeated practice.

Parents reacted favorably to personal thoughtfulness and individual treatment. They appreciated it when they and their babies were greeted by name and when the staff showed interest in their other children and could sympathize with some of their problems. Most parents preferred

reports and explanations initiated by the staff, as they often feared their questions would be considered ignorant. Many expressed fear of sophisticated equipment until the functions were explained. We were reminded that parents appreciate thorough explanations in nonmedical language.

Parents commented on real or imagined laxities in nursing care, such as skin rashes and excoriated buttocks. These occurrences should be explained whenever possible so parents do not get the impression nurses are unaware and neglectful.

Most parents expressed some fear and inadequacy concerning discharge. They were relieved somewhat by written discharge instructions and the knowledge they could call the nursery at any time if problems arose. Follow-up telephone calls or home visits were usually found beneficial, as parents forgot many questions in the excitement of discharge. Many desired further general information about care, special precautions, and expected growth and development of premature babies.

In summary, the most incisive and informative comments were from parents who had at times most taxed our powers of diplomacy and understanding. This leads me to conclude that the greater the parent involvement, the greater the satisfaction, both for the consumer and the provider of the service.

# References

- 1. Averill, J.R. Grief: its nature and significance. *Psychol. Bull.* 70:721-48, Dec. 1968.
- 2. Barnett, C.R., Leiderman, P.H., Grobstein, R. and Klaus, M. Neonatal

separation: the maternal side of interactional deprivation. *Pediatrics* 45:2:197-205, Feb. 1970.

# **Bibliography**

Fanaroff, A., Kennell, J.H., and Klaus, M. Follow-up of low birth weight infants — the predictive value of maternal visiting patterns. *Pediatrics* 49:287, Feb. 1972.

Kennell, J.H., Slyter, H., and Klaus, M. Mourning response of parents to the death of a newborn infant. *New Eng. J. Med.* 283:7:344-49, Aug. 13, 1970.

Richmond, J.B. The mother's tie to her child. *Pediatrics* 45:189-91, Feb. 1970.

# Ten tips on preparing research proposals

The real or imaginary hurdles associated with the preparation of grant applications need not be intimidating if you follow the practical suggestions offered here.

Walter O. Spitzer, M.D., M.H.A., M.P.H.



Potential investigators with a good research idea often fail to take even one step in implementing that good idea if it is apparent they need resources not ordinarily available to them. They become unduly discouraged about the prospect of writing a study protocol, submitting themselves to appraisal by peers, and overcoming all the other real and imaginary "hurdles" associated with the preparation of grant applications.

Unfortunately, health professionals outside universities and colleges, whose ongoing contact with the "real world" tends to make their work particularly relevant to the needs of their patients or their own disciplines, are those most easily discouraged. They assume they do not have the ability or the credentials to generate support for a project, and they do not seek such support.

Although some skills are necessary and there is a "right way" of doing certain things, much of what is needed

Dr. Spitzer is Associate Professor, Department of Clinical Epidemiology and Biostatistics, Faculty of Medicine, McMaster University, and Co-Director, Educational Program for Family Practice Nurses (Nurse Practitioners), Division of Health Sciences, McMaster University, Hamilton, Ontario. He thanks Dr. Dorothy J. Kergin for her helpful suggestions and for reviewing the manuscripts.

**MARCH 1973** 

to prepare a research proposal is common sense. I have learned most of the points to consider about writing grant applications from peer reviewers who have made comments, suggestions, and objections about my own proposals

during the past few years.

Some applications were successful, some were not. Unsuccessful applications have had their long-term payoff in that many mistakes have been avoided in subsequent attempts, and it has been possible to assimilate quickly the benefit of the experience of more senior investigators.

The suggestions that follow are not intended as a handy "cook-book" to guarantee success in shaking down the money tree of research foundations and agencies. They are simply some tips learned from many of my colleagues, and which I am passing on to the reader. Anybody venturing into this field of activity is sure to make mistakes at first. The following suggestions may help to avoid some predictable pitfalls.

# 1. State your objective and study questions clearly

Once you come upon a good idea, an intriguing hypothesis, a burning question, or an important demonstration project, write your thoughts promptly. Then, preferably within days, carefully restate your project or study. Two important steps must be taken, as neglect of either one will frequently jeopardize the quality of the rest of your paper: First, write the objective of the study and, second, formulate questions about your study, research project, or demonstration model.

Try to limit the questions to one or two. If you find yourself writing more than five or six questions, your objectives may be vague and your concepts woolly. Questions should be phrased to permit objective, preferably quantitative, answers. Here are some examples:

Objective: To determine whether introduction of a ward manager to inpatient units of a teaching hospital actually increases the availability of nurses for direct patient care.

Related Study Questions:

1. On the basis of a time-and-motion nurse activity study, is the proportion **MARCH 1973** 

of nurses' total time devoted to clinical care increased among nurses in a unit with a ward manager, as compared to nurses in a control unit without a ward manager?

2. How many minutes of a patientday does a nurse interact with patients in a unit with a ward manager, as compared to the number of minutes per patient-day with patients from the control unit?\*

Objective: In an ambulatory family practice setting, it is proposed to ascertain whether history-taking is an acceptable function for the nurse practitioner.

Related Study Question: In what proportion of episodes where both a physician and a nurse practitioner take a history from an ambulatory familymedicine patient:

- 1. does the nurse practitioner fail to obtain clinical or other data that were elicited by the physician and considered subsequently to be essential information for appropriate management decisions?
- 2. does the nurse practitioner secure data that influences case management decisions that would not have been secured by the physician?
- 3. does the patient express dissatisfaction (or satisfaction) with having the nurse practitioner carry out this function?

Once you have rewritten your objectives and your study questions, review them with colleagues whose opinion you respect. They are likely to give you a candid opinion on the clarity of the objective, the feasibility of the project, and whether the research questions are sensible and indeed researchable.

# 2. Study the background literature

It is important to determine whether the kind of study or project you propose has already been done. Usually, those who will be asked to review your application are knowledgeable in the field

\*These questions lead to a quantitative analysis of data. A qualitative analysis of nurse-patient interaction requires a more complex study design, and a greater scope of expertise to conduct the study.

and will be aware of current and past work reported. It is unlikely that you will be granted support for projects that are nothing more than "reinventing the typewriter.'

When you have reviewed the literature, write it up briefly. If you are not breaking completely new ground, you should demonstrate how your project sheds new light on a problem already studied by others, and show how you will be advancing new knowledge. If your emphasis is on application of existing techniques or knowledge, you should indicate the relevance of your work in terms such as "benefit to patients," or "greater efficiency attained."

# 3. Decide on general strategy

Before considering detailed tacties that you might adopt, such as selection of comparison groups, delineation or criteria, selection of samples, or scoring techniques, it is important to design your general strategy. Are you proposing a demonstration model? Will you be conducting a survey? Do you plan a true experiment? The nature of your objective and of your research questions will usually suggest the proper strategy.

There may be times, however, when two or more approaches could be suitable. The one you adopt may be chosen on the basis of being the most feasible

and the most practical.

Here it seems appropriate to mention a common pitfall. Often, support is sought for a project that is clearly not research at all. The investigators are interested in establishing a service or an educational project, for example, a sex education counseling center for high school students developed and staffed by nurses.

The sponsors of the project are not particularly interested in research or evaluation, but develop a proposal in research format because they are convinced, or have been told, that their project will not be funded unless it can be evaluated as a demonstration model or research project. It is usually clear to reviewers of this type of application that its objectives are not oriented to research or evaluation, but to service, education, or other priorities, and that research has been "piggybacked" simply to meet the criteria of a funding agency.

THE CANADIAN NURSE 31

It is uncommon for such projects to be funded as research. Sponsors of nonresearch proposals should apply to granting agencies having terms of reference that provide funds for service or educational programs on their own merit.

# 4. Identify the most appropriate funding agency to which you can apply

You should investigate whether accepted procedures or ethical considerations justify applying to more than one funding agency concerning the same project. It is important to make a decision about possible sources of funds at this time as the tactics you specify in the detailed research design may be influenced or determined in part by the known policies of a funding agency. Most funding agencies have published terms of reference, which you should obtain and study before proceeding.

5. Seek consultation from experts

This is the time to consult with experts, although you may already have spoken with colleagues or other advisors when you formulated the objectives and study questions. If it is possible, you are well advised to consult with resource persons, such as research methodologists and biostatisticians, or experts in the field that concerns you. A common pattern is to seek consultation after a grant has been rejected, or after the data have been gathered. Then it is usually too late.

When you consult about the research design, it is wise to consider some ethical questions. Are there any risks to patients or citizens who may become study subjects? If so, do these outweigh potential benefits to those individuals or to the population in general? Are study subjects free from invasion of privacy and assault? Are reasonable safeguards taken to protect the confidentiality of personal or clinical information? Is it ethical to withhold some treatment from a control group?

The following paragraph quoted from a grant application to support survey research is an example of statements often included in proposals:

"The individuals and families involved in this investigation would enjoy

# Suggested Outline for a Research Protocol

- A. Summary (300 words or less)
- B. Main Protocol
  - 1. The objective and research question(s)
    - (a) objective
    - (b) question(s) (they may be restated as hypotheses if desired or appropriate)
    - (c) significance of the problem in health care or biomedical science
  - 2. Review of pertinent literature
  - 3. General strategy to conduct the study, including a discussion of the rationale for the choice of method (e.g., retrolective study, survey, experiment, etc.; use or not of comparison groups)
  - 4. Specific procedures or tactics
    - (a) kinds of information collected;
    - (b) procedures used in the collection of information;
    - (c) from whom;
    - (d) by whom;
    - (e) where;
    - (f) schedule for collection of information;
    - (g) copies of letters, recording forms, interview schedules, questionnaires, etc., should be included either in the text or appendixes as deemed appropriate.
    - 5. Ethical considerations
    - 6. Methods of data preparation
  - 7. Method of analysis, including statistical aspects, if appropriate (for sections 6 and 7 justify use of computers if planned)
  - 8. Dummy tables, charts, and graphs
  - 9. Budget
  - 10. Justification of budgetary items
  - 11. Criteria for success of the project

freedom from assault; the privacy and ability to withdraw from the experiment at any time, as well as confidentiality of all personal information obtained, would be scrupulously protected. The applicants have carefully weighed the potential gains from new knowledge arising from this investigation and have concluded that they vastly outweigh the risks to the individuals included in this project. Consent to take part in this investigation would be requested only after full disclosure of the nature of the project and of any potential risks associated with the deli-

very of health services in this fashion."

Some agencies require a statement on ethics in each proposal.

# 6. Specify beforehand the criteria concerning your study questions and the criteria for the success of your project

Unless you indicate what kind of objective or quantitative answer to your research question constitutes a particular verdict about the subject or issue you are evaluating, your proposal may be regarded as a self-fulfilling prophecy. The exercise of specifying criteria

for the research questions in advance usually distinguishes the disciplined and rigorous investigator from the wishful thinker who is "out to prove a point." If we refer back to the first question of the first sample objective cited earlier, a corresponding criterion for success might be:

Criterion: The new method will be judged successful if the average number of minutes of nurse-patient interaction per patient in the experimental group exceeds that of the control group by 20

percent.

Often, one tends to consider a negative verdict about the subject under study as an indication that the project has failed. Such an assumption is unwarranted. A project or study may have been successful in that it provided strong, irrefutable evidence that settled a question about a particular issue. Whether or not a study or project is successful is not determined by the verdict to which it led, but by the quality of the evidence it yielded. Accordingly, it is frequently useful to spell out criteria for the success of a project separately from the criteria concerning the study question.

# 7. Be as brief and clear as possible

Reviewers of grants are not particularly interested in reading dozens and dozens of typewritten pages. Large studies that may involve several centers can have a complex design, and the required detail of description then results in an application of considerable length. Nevertheless, most successful grant applications for clinical or health care research are no longer than 10 to 15 pages. Unnecessary verbiage reflects unfavorably on the applicant's ability to think clearly and communicate effectively.

The suggested outline for grant applications on page 32 will require modification for each study; but it may be useful as a skeleton and as a point of departure.

# 8. Keep appendixes and supporting documents to a minimum

Lengthy appendixes, supporting documents, and bibliography result in a longer and more cumbersome application. The reviewer usually feels compelled to read them and is often irritat-

ed after doing so because appendixes generally do not contribute much. An appendix or a supporting document should be included only if essential to the understanding of the main body of the application (for example, the format of an interviewing form), and if it is clearly inappropriate to include the information in the main body of the application. If in doubt, state briefly in the main text what an ancillary document contains, and indicate it is available on request. Do not attach it.

# 9. Assess realistically the resources required and available to implement your project

Do not propose to hire categories of professionals not available in your setting or in your community. If your project depends on nonexistent human or other resources, you should not be

applying in the first place.

Determine carefully the funds needed for salaries, equipment, supplies, specialized services, consultants, and other items. Underestimating what you require will cause you unnecessary difficulties when implementing your study. Overestimating resources deliberately will strain your credibility either at the time of the first review or when you submit an annual progress report.

The peers who judge the merits of your proposal and assess its progress as you submit renewal requests are usually aware that errors of judgment can be made in estimating requirements for a study; most of them have had similar troubles and are sympathetic. They can be expected to be reasonable about applications for amendments of budgets when these seem to be sensible and caused by unforeseeable contingencies. It is much better to submit supplementary requests, if need arises, than to "pad" a submission as a protection against contingencies.

# 10. Prepare and justify your budget

Most granting agencies provide preprinted application forms that include the required breakdown of budgetary categories. But many research proposal budgets are submitted without justification for the various categories of expenditure. Moreover, budgets are frequently not detailed enough to enable an appraiser to link items of disbursement with the activities and tactics described in the project.

The budget justification should explain the need for each individual for whom salary or wages is requested, every item of equipment and category

of supply, travel, and so on.

It is wise to identify any major expenditure for which the estimates are not firm. Should budgetary difficulties concerning an uncertain estimate arise later; prior identification will have paved the road for the approval of amendments.

# Conclusion

Preparing a research protocol and applying for its support need not be dreaded as an unavoidable preamble to rewarding research activity. The process of designing the project, exploring feasible approaches to implementation, identifying the resources necessary, and communicating all this information in a grant application is an integral component of investigative activity. It is also intellectually challenging and can be a lot of fun.

# Bibliography

Abdellah, Faye G. and Levine, Eugene. Better patient care through nursing research. New York, Macmillan, 1965. p.147-150, 200-221.

Association of Universities and Colleges of Canada. Canadian Universities' guide to foundations and granting agencies. Ottawa, 1971.

Krathwohl, David R. How to prepare a research proposal; suggestions for those seeking funds for behavioral science research. Syraeuse, N.Y., Syraeuse University Bookstore, 1966.

Sackett, David L. and Olynich, A. Organization of an evaluation project. In Methods of Health Care Evaluation. Readings and exercises developed for the National Health Care Evaluation. Seminars. Edited by David L. Saekett and Marjorie S. Baskin, Hamilton, Ontario, McMaster University, 1971. p.14-1 to 14-8.

# Gestational diabetes — when teaching is important

Pregnancy can trigger diabetes. The program developed at the Tri-Hospital Diabetes Education Centre for gestational diabetics may help in understanding the condition, and recurrence in subsequent pregnancies or development into overt diabetes in later years may be postponed.

**Elizabeth Laugharne and Felicity Duncan** 

Gestational diabetes is a recently defined form of diabetes in which the unmasking factor is a pregnancy.

In the past 10 years medicine has become more concerned with early diagnosis of this condition, and screening programs for the pregnant woman have been established throughout the world. Recent trends show that gestational diabetes is diagnosed in approximately one out of every 100 pregnant women in a tested population. O'Sullivan found approximately one in 116.1

It usually shows a remission following delivery and often reappears in subsequent pregnancies. Approximately 15 to 30 percent of women with gestational diabetes become overt diabetics within 10 years, while some never do.<sup>2</sup>

The diabetogenic effect of pregnancy is due primarily to insulin antagonism. The production of placental lactogen, growth hormone, estrogens, and, to a lesser extent, progesterone, which antagonizes insulin, tends to unmask latent diabetes in genetically predisposed women. The nondiabetic pregnant woman with normally-functioning islet cells compensates for this antagonism by increased production of insulin.<sup>3</sup>

Clues leading to the diagnosis of gestational diabetes are based on such suggestive factors as obesity; a history of large babies (more than 10 pounds at birth), repeated miscarriages, or stillbirths; and a family history of diabetes.<sup>4</sup>

Diagnostic tests can include fasting blood glucose levels, two-hour blood glucose levels, or a glucose tolerance test. Because the values of glucose tolerance tests are normally raised by some 20 mg. percent in the last trimester of pregnancy, and glycosuria is also common in pregnancy due to the lowering of the renal threshold, interpretation of tests becomes more difficult and often results in the need for more frequent blood glucose determinations.

Since some women who develop gestational diabetes will become overt diabetics within 10 years, they should be reassessed at intervals for the rest of their lives and should become familiar with the symptoms of the disease, and be aware that it can also be present without symptoms. It is important, therefore, that health teams establish special programs for the gestational diabetic, with goals somewhat different from those for the pregnant diabetic.

Nurses, as members of the health

Ms. Laugharne is the nurse coordinator of the Tri-Hospital Diabetes Education Centre, Toronto. Ms. Duncan was the diabetes teaching nurse at the Toronto General Hospital for five years and is now with the Tri-Hospital Diabetes Education Centre, Toronto, Ontario.

team, will be involved in the community health center educational program, the inhospital teaching program, and the follow-up program after the gestational diabetic has returned home.

The objective of the health team is to assist the expectant mother to understand the complications that might arise due to diabetes during her pregnancy, and the manifestations of gestational diabetes, its treatment, and prognosis.

# Community health center program

The program for gestational diabetics in a community health center, such as the Tri-Hospital Diabetes Education Centre, has many benefits. The teaching nurse and the teaching dietitian are prepared to answer the numerous questions gestational diabetics ask, and to spend the necessary time to allay any fears they may have.

At the center, we segregate gestational diabetics from diabetics who are pregnant. Unless or until the gestational diabetic becomes overt, there is little to be gained in discussing with her such complications of diabetes as hypoglycemia and ketoacidosis, for example. In fact, to do so would only add to her anxieties.

Our teaching program for gestational diabetics provides for the medical, nursing, and dietary needs of the individual concerned. The teaching

**MARCH 1973** 

nurse and the dietitian work closely with the clinic nurse.

When teaching the mother-to-be, we include:

Importance of prenatal care. The need for regular visits to the physician, the reason for the medical team (internist, obstetrician, pediatrician) approach to pregnancy, and the need for frequent laboratory analyses are explained.

Urine testing. The patient is taught how to test urine and to interpret and record results, both for glycosuria and ketonuria. Accuracy in testing and the importance of record-keeping is emphasized. The patient is made aware of the renal threshold and its significance.

Obesity as a health hazard. The patient is made aware of the importance of diet and the influence of obesity as the stress factor in the development of adult diabetes.

Symptoms of diabetes. The patient and/or her family must become aware of the danger signals to look for in the future, and of the need for careful supervision during any subsequent pregnancy.

It is of paramount importance that the expectant mother understand the role of diet in the treatment of gestational diabetes, and the ideal time to teach this facet of care is during her visits to a community health facility, and, as opportunities present themselves, in her own home.

To meet her dietary needs, the expectant mother must fully understand:

- normal nutritional needs and how to meet them.
- nutritional needs during prengnacy and how to meet them.
- the need for weight control during pregnancy and afterward.
- · diabetic diets.
- the need to choose foods that help keep her healthy, control her diabetes and her weight during pregnancy.
- "forbidden foods" such as cyclamates.

- how to use the "exchange" system.
- how to measure and weigh foods.
- how to prepare food properly.
- how to follow a meal pattern that ensures proper distribution of carbohydrate in the diet.
- how to manage restriction of salt intake, if necessary.

In the first trimester of pregnancy, sensitivity to insulin increases and prediabetes is unlikely to progress to chemical or overt diabetes. During period, insulin requirements usually decrease. The need for more insulin usually arises in the third trimester, and this is when the physician is more likely to detect chemical or overt diabetes in the woman whose glucose tolerance test (G.T.T.) has previously been normal. However, no two cases of gestational diabetes are the same.

Inhospital teaching program

Gestational diabetics may be admitted to hospital early in the third trimester for monitoring of the fetus. During their stay in hospital the focus is on the state of the fetus and the mode of delivery. However, the diabetic teaching nurse takes this opportunity to reintroduce and reinforce teaching carried out in the community health center.

The inhospital period also gives the teaching nurse an opportunity to assess how much the patient has learned and what use she is making of the knowledge gained. The expectant mother's apprehension about admission to hospital increases the need for support by the health professionals in allaying fears and anxieties relating to the outcome of the pregnancy.

If insulin from an exogenous source is required, the teaching nurse gives individual bedside instruction and assistance at this time. The importance of urine collections for both 24-hour estriol determinations and glycosuria can be explained to the patient. Further, if Clinitest has been used, the need to change testing materials can be reviewed — because of the production

of lactose in the third trimester, a change from Clinitest to Diastix or Clinitex becomes necessary.

Another important area of teaching for the gestational diabetic is family planning, which should be introduced in the late prenatal period, and discussed again in the early postpartal period. The physician usually does not recommend the oral contraceptive as a method of family planning for the gestational diabetic because of the recognized involvement of steroids in carbohydrate intolerance. However, the intrauterine contraceptive device is often recommended, and there are other forms of contraception (foams, creams, or the diaphragm) that are quite reliable, if used as directed.

# Community resources

Health educators agree that followup of the gestational diabetic is imperative, both prenatally and postnatally. Medical supervision must be maintained, and it is hoped that the teaching by all members of the health team is understood and carried out by the woman for whom it is planned.

Public health nurses of the visiting nurse agencies and departments of public health, having entry to homes as they do, are in a position to maintain effective liaison between home, physician's office, hospital clinic or community health center, and inhospital

services.

The gestational diabetic may be exposed to and involved in excellent educational programs planned especially for her. However, for such programs to be effective, she must be able to apply what she has learned in her own home. But, if she is unable to do so, the public health nurse can help.

Case history

Mrs. B's family doctor made the diagnosis of gestational diabetes in May 1972, early in the third trimester of her second pregnancy. He referred his patient to an obstetrician and gynecologist who had her admitted to the Toronto General Hospital.

**MARCH 1973** 

Mrs. B., 33 years old, had weighed 10 lbs. at birth and 118 lbs. at the time of her marriage at 22 years of age. When 27 years old, she had a miscarriage at 5½ months. Her weight then increased to 227 lbs. Prior to this pregnancy she had managed to get her weight down to 195 lbs., but it had now returned to 227 lbs.

On admission to hospital, Mrs. B's blood sugar was elevated; she had 5 percent glycosuria, a trace of proteinuria, and moderate ketonuria. Insulin therapy was initiated (Lente 30 units and Regular 5 units q.a.m.) with a 1,000-calorie diabetic diet.

During this first admission, Mrs. B. was referred to the Tri-Hospital Diabetes Centre for registration in the regular program. It was soon evident that, although the diagnosis of diabetes upset her greatly, her main concern was for the condition of her baby.

She was able to self-inject her insulin but unable to cope with the preparation of a mixed dose of insulin. As Mrs. B. cried during class, it was decided to withdraw her from it. The diabetic teaching nurse at the hospital assisted her until discharge, and she responded well to individual tuition.

Mrs. B's problem gave reinforcement to our need for a separate program for the gestational diabetic, and led to the planned program outlined in this paper.

When Mrs. B. was discharged, her insulin was not increased because of her expected activity at home. She was, however, instructed to return for continuing prenatal care and close management of her diabetes.

On readmission to hospital at 35½ weeks' gestation, mild hypoglycemia had developed. Her examination showed: creatinine clearance of 99 ml/hr.; 24-hour urine protein below 100 mg. percent; normal fundi; normal blood pressure; no proteinuria, and minimal ankle edema; and her insulin requirements decreased to Lente 18 units

On July 9, when the 24-hour estriol

excretion fell rapidly, it was decided to perform a cesarean section and a tubal ligation.

Mrs. B. gave birth to a male infant weighing 3,850 Gm. At birth he experienced respiratory distress and abdominal distension (ileus associated with a meconium plug). He was treated in the intensive care unit at The Hospital for Sick Children, where his condition improved after a difficult initial 48 hours. Initially, postpartum tests showed blood sugars of 114 mg. percent, falling to 16 mg. percent, then 64 mg. percent during the first day. Next day, the blood sugar was reported as 170 mg. percent.

Mrs. B. was placed on a normal diet. However, a glucose tolerance test on the eighth day postpartum gave the following results: fasting 117 mg. percent, half hour 175 mg. percent, one hour 231 mg. percent, two hour 239 mg. percent, three hour 156 mg. percent.

There was *no* glycosuria, indicating a high renal threshold.

The diabetologist's comments were: "Normal fasting blood sugar and sharp fall in sugar between two and three hours indicate chemical diabetes with delayed insulin release."

Mrs. B. was discharged on a 1,000-calorie diabetic diet, and was to be checked in a week by the diabetologist. Her physician hoped that she would not need medication for diabetes and that, when her weight returned to the ideal of 125 lbs., her G.T.T. would return to normal.

## Summary

It has long been recognized that lack of knowledge on the part of diabetics, whether overt or gestational, constitutes one of the primary stumbling blocks to good control. Comprehensive patient education programs have been established to correct some of the serious existing deficiencies. Health teams have updated their knowledge regarding conditions such as diabetes. As a member of the health team, the nurse is playing a major role as educator

and is in the unique and fortunate position of being able to initiate and improve coordinated teaching programs for the gestational diabetic.

## References

- 1. O'Sullivan, John B. Gestational diabetes: unsuspected, asymptomatic diabetes in pregnancy. *New Eng. J. Med.* 264:21:1082-5, May 25, 1961.
- 2. Ibid.
- 3. Freinkel, Norbert. The effect of pregnancy on insulin homeostasis. *Diabetes* 13:3:260-7, May/Jun. 1964.
- Carrington, Elsie R. et al. Evaluation of the prediabetic state during pregnancy. *Obstet. Gynecol.* 9:6:664-9, Jun. 1957.
- 5. Kenshole, Anne B. Oral contraceptives and diabetics. *Mod. Med. Can.* 26:12: 35-6, Dec. 1971.

# **Bibliography**

Ellenberg, Max and Rifkin, Harold. Diabetes mellitus: theory and practice. New York, McGraw-Hill, 1970.

Hazlett, B. and Gare, Douglas. The pregnant diabetic. *Mod. Med.* 26:12:37-40, Dec. 1971

Joslin, Elliott Proctor. Diabetes mellitus, edited by Alexander Marble, et al. 11ed. Philadelphia, Lea and Febiger, 1971.

# idea exchange

# Patients' recreational program

Elsie I. McLellan

The nurses on the medical wards of the Winnipeg General Hospital recognized the need for a recreational program for patients. They held a ward staff conference to discuss the possibility of getting such a project underway, and decided that the medical nursing supervisor should contact staff of other departments who might be interested in becoming involved.

At the first interdepartmental meeting we decided to plan an eight-week pilot project. At the end of this time, the committee and the departments involved would reassess the program in terms of attendance, finances, and

availability of volunteers. Objectives for the patients' recreational program are: to meet the socialemotional needs of patients, and to help overcome slight social isolation while away from family and friends, to meet the recreational needs of patients; to create an atmosphere in which patients can meet and converse freely; and to develop an understanding relationship between patients and staff.

Patients are selected for the recreational activities by the head nurse, in conference with the medical staff

during ward social rounds.

The committee included representatives from: White Cross Guild (the volunteers' organization); social service; department of nursing; occupational therapy; chaplain's office; and the head nurses' group.

Meetings of the committee are called as necessary by any member of the

committee.

After some discussion the following program was arranged: Tuesday afternoon — bingo session; Wednesday evening — film show, either a feature film or travelogue; Thursday afternoon — handicrafts; and Friday afternoon — film show.

Permission was obtained to use a nearby conference room for these ses-

The White Cross Guild donated \$100 to finance the project, and small prizes for the bingo sessions. The hospital branch of a bank donated some handsome notepaper folders and

Films were obtained from the National Film Board and Manitoba government film library at no cost. Watching films is something for patients to do and may relieve boredom, loneliness, and restlessness.

Under the guidance of an occupational therapist, the patients made 250 Christmas stockings during the handicraft sessions. The stockings were filled with donations from people outside the hospital who learned about the project from the patients. On Christmas day, 1971, these stockings were distributed to all patients on five medical wards and one extended care ward. Santa was played by one of our former patients.

During the eight-week trial period, 410 patients attended the activity sessions. Bingo was an outstanding success and a great favorite with all patients. The committee elected to continue the trial program until summer; the White Cross Guild closed down for the summer vacation, and it was difficult to continue without their

help.

The author is medical nursing supervisor at the Winnipeg General Hospital, Winnipeg, Manitoba.

# Daily ICU conference improves patient care

The daily conference in the medicalsurgical intensive care unit of the Misericordia General Hospital has become indispensable. All our staff participate — cardiologists, internists, radiologists, registered nurses, respiratory technologists, physiotherapists, and dietitians — and everyone — from the knowledge-seeking student to the accomplished medical practitioneris encouraged to contribute verbally.

We begin with a short review of

electrocardiographic test tracings to familiarize health team members with life-threatening arrhythmias needing immediate treatment. Then, histories and clinical findings of all medical and critically-ill surgical patients are reviewed in detail, followed by assessment of patient treatment and management. Electrocardiograms and chest x-rays are projected on a screen and interpreted.

Topics for discussion may be drugs,

their interactions, side and toxic effects; evaluation of the management of a recent post "99"; acid-base balance; recordings on heart sounds; or electrophysiology. Often the doctors or instructor follow up our conferences with clinical teaching.

Our daily conference keeps open the lines of communication between doctors and nurses. Thus, there is a continual expansion of knowledge and expertise to be applied to the

THE CANADIAN NURSE 37

# idea exchange

patient care plans — for future patients as well as those of present concern.

Nurse participation at a decisionmaking level is reflected in improvement in powers of observation and nursing care. So often the nurse is the first to assess the patient's immediate condition and to obtain his history. Often, too, the nurse initiates emergency treatment before medical assistance can be obtained. In conclusion, daily ward conferences in any area of medicine can be vital to quality nursing care, depending as it does on applying "better than our best"

The nursing staff of the Intensive Care Unit of the Misericordia General Hospital, Winnipeg, submitted the above description of their daily conference through their supervisor, Olga Rozwood.

# Students on a curriculum revision committee

Morene Gayle Weinstein

In May 1972, the concept of a curriculum revision committee evolved at the Winnipeg General Hospital school of nursing. Ten teachers and two students, Catherine Anne Whiting and I, were members of this committee. The students' role was to present constructive criticism on deletions and additions to course content from the first- and second-year classes, from which we were respectively elected.

One factor we had to bear in mind as we did our committee work was the time element. The classes to follow us would have a course approximately two years in length. Serious thought had to be given to what we, as students, would like to see in a program that functioned within a two-year limit. The instructors' dilenma in curriculum planning became more evident and meaningful to us at that time. How naïve we were!

We went to the second meeting a little less smug than to the first and opened our minds and ears, ready to listen to what the teachers had to say. It seemed to us the teachers came to the meeting with the same idea in mind, ready to listen to our views and comments. As the meeting progressed, we found out how approachable our teachers were; they learned we were as concerned as they were to reach the main objective — the best possible

type of learning for the student. What did we as students feel should be taught in each of the two years? How did the teachers view us and our capabilities, and how would we cope with their expectations?

In the next few meetings, lengthy discussions were held about the level at which we felt other students should be functioning in each year of the course. We were given opportunities to express our ideas and to have them understood and commented upon. We talked about particular times in the students' learning when we believed teachers were expecting too much or too little. Perhaps it was during these discussions that many of the teachers reflected back to their student days and really understood our feelings. Teachers and students have much to share. Sharing, as we view it, is an important concept.

To cite one example of deletion and addition, we students saw a benefit to future classes if the study of nasopharyngeal suctioning were deleted from first-year and added to second-year studies involved with tracheal care. As well, we proposed that various skills such as taking blood pressure, TPR, and so on, be initiated earlier in the first year and that less emphasis be placed on skills such as bed making and baths, which could be accommodated with other experiences on

the ward. (This is being done with the class of 1974 at WGH.)

Our opinions on teachers' suggestions were welcome. One such idea was that the majority of cardiac drugs be taught in the second year by the pharmacology teacher, rather than in first year. We felt this, too, would be more meaningful to students who were having experience in medical-surgical areas. These were just two of the many suggestions discussed.

We discovered how much time and effort goes into the planning of a course and can now more fully appreciate

our studies.

We would suggest that students who are interested in finding out how a course is derived, or who feel they have something of benefit to offer others, see the teacher in charge of the curriculum and ask to participate. It's a tremendous experience and one we believe students will enjoy.

Ms Weinstein graduated in November 1972 and is working on a medical ward at the Winnipeg General Hospital.

# Health and community information services

Information booths in two suburban shopping plazas and an action center in the urban renewal area of Thunder Bay, Ontario, are the scene of an effort to provide preventive health care and community information. The need for an information clearinghouse and the health concerns of their clients make this project satisfying and challenging to seven registered nurses.

# **Heather Kibzey**

A young woman hesitantly approached the nurse on duty in the health and community information booth and asked about breast examination. Her two children, aged 9 and 7, were with her in the shopping plaza.

The nurse gave the client a Canadian Cancer Society pamphlet, *Breast Self-examination*, which contains step-by-step instructions. She used the booklet for health teaching, telling the woman what to look for during the exam, and the frequency and reasons for examining her breasts.

She also indicated further steps the woman should take if she were concerned about any symptoms she discovered.

The woman thanked the nurse and said, "My mother had cancer. I know I should examine my breasts regularly, but I just didn't know how to go about it or what to look for."

The client confided to the nurse that she was reluctant to ask her physician because the subject embarrassed her, and her doctor was so busy she hated to take up his time with such a "trivial" request. She said she would attempt the self-examination at home that evening.

Health & Community Information Services was established in Thunder Bay, Ontario, in February 1972, with a grant of \$39,277 from the Local Initiatives Program of the federal government. The social services department of St. Joseph's General Hospital applied for the grant. The project includes an information booth in each of two suburban shopping plazas and an action center with phone-in service on South Cumberland Street in the urban renewal area of Thunder Bay.

# Background

St. Joseph's Hospital is relatively close to the Cumberland street area and hospital officials wondered whether they were meeting the special needs of the low-income and indigent persons of the area. They thought there were many persons who needed medical and social assistance who would not or could not use existing institutional facilities and who might be contacted through an outreach service.

Office accommodation was found in part of an old hotel, slated for demolition in 1973. The other half of the building is used as a drop-in center for

Ms. Kibzey, a graduate of McKellar Hospital school of nursing, Thunder Bay, Ont., worked for two years in the special medical unit at St. Joseph's General Hospital, Thunder Bay, assisting with the treatment program for persons with alcoholism and emotional disturbances. She has been with the Health & Community Information Service project since its inception in February, 1972.

individuals of all ages, where they may socialize with their cronics or obtain light meals at minimal cost; it is run independently of the information services

The project stresses preventive aspects of medicine and health teaching. We hope people of the area will receive minor medical attention at the health and community information services office before their medical problem becomes serious. As an offshoot of the concept of health teaching, booths where information and health teaching could be dispensed in a somewhat different manner were put up in two new suburban plazas. In effect, we are conducting two programs.

# **Project organization**

The project currently employs 10 people: seven registered nurses, an office coordinator, and two social field workers. The nurses work three days a week in seven-hour shifts. One shift each week is spent in the Cumberland Street office and two in the plazas. In this way, the nurses obtain a good working knowledge of the total operation.

The nurses' function on Cumberland Street is to provide first aid on or off the premises; we encourage people to come to us if possible. We do minor procedures, such as compressing, blood

**MARCH 1973** 



Joan Morris, center, one of the nurses staffing the health and community information booth in a shopping plaza in Thunder Bay, Ontario, provides pamphlets and explanations in answer to shoppers' questions.

40 THE CANADIAN NURSE

pressures, dressings, soaks, or dispensing of prescribed medications.

If, in the nurse's judgment, further medical attention is warranted, she tries to obtain a doctor's appointment for the person or sees that he gets to the hospital emergency department. We have leased a small car to enable the field workers to provide this service, since often our contacts become fearful and leave before the doctor arrives, or get high on liquor or pills and forget to go. Follow-up is a necessary part of our service.

The Cumberland Street operation has been assisted greatly by the field workers. Initially, we realized that, due to fear and/or ignorance, people in the area would have to be searched out and brought to the office for help. These field workers do that — they visit flophouses, back alleys, the waterfront, and the drop-in center and encourage people who require medical attention, or assistance with social problems, to come in.

They help fill out applications for welfare or unemployment insurance; find housing, either temporary or permanent; act as a buffer between the individual and existing agencies; assist clients in getting to doctors' appointments or the hospital emergency department; or visit them in hospital. The individual is encouraged to do as much as he can with our assistance, but care is taken not to make him too dependent on our services.

We are currently building a small file on individuals in the Cumberland Street area, with pertinent personal information on doctors consulted and medications prescribed, to try to cut down on the "shopping around" for drugs, which is quite a problem.

# Plaza booths

The plaza booths are set up in the mall and are readily accessible. Our contacts tell us this is what makes the service so valuable. To attract people to the booths, pamphlets on a variety of topics are displayed and given free of charge. The topics are wide-ranging: nutrition, cancer, birth control, venereal diseases, safety, child care, drugs and alcohol, and more.

The nurses at the booths are on duty from 2:00 to 9:00 P.M. weekdays and 11:00 A.M. to 6:00 P.M. on Saturdays. These are the best times from the standpoint of customer flow in the malls. The nurses attempt to engage each contact in conversation and to do some

form of health teaching on the requested information if the person is receptive.

A large, cross-referenced Kardex is available for information and, if the nurse does not have the requested information on hand, she may phone the main office or make arrangements to get the information to the person at a later date. Stress is placed on dispensing correct information and always giving the individual some definite answer. In addition, films on a wide range of topics for health teaching purposes were shown during the summer. These were favorably received and appeared to stimulate follow-up questions and discussion.

Extensive records are kept on each contact made by the nurse or field worker. Individuals are categorized according to age, topic of inquiry, disposition, area of lodging, how they found our service, if they used our service before, and length of contact. It is not difficult to obtain this information from people if it is done discreetly and if they know the information given will remain anonymous and confidential.

All health teaching done is put on a special card that can be used for future reference.

From our information sheets, we found most health teaching is done on nutrition, with cancer, smoking, drugs and alcohol, birth control, and heart disease following as main areas of concern. From May 1 to September 30, 1972, we had over 4,300 contacts.

## Relevance

The service we provide appears to be unique; no one else offers the combination of health and community information. No question is too small or unimportant, and we welcome new sources of information. Our nurses read avidly and keep up-to-date on a wide variety of community activities and current trends.

We have attempted to work as closely as possible with the existing community agencies and not duplicate services. The local Detox Centre for alcohol users will now accept persons on our recommendation, providing we feel they are physically sound. Recently, we have been introducing student nurses from the Lakehead Regional school of nursing to our services as a background for their community experience.

The upper floor of our building is currently vacant; it is to be set up as a hostel under the sponsorship of the Ontario Métis and Non-Status Indian Association. One of our field workers is on the steering committee to establish this hostel.

# **Future plans**

A "free clinic" in the Cumberland Street area appears to be a basic need; the hospital admission rate of persons from the area, through St. Joseph's emergency department, is double the general population rate.

If preventive care were provided in their own area, persons who do not normally see a doctor may be helped, and problems may be alleviated before they become serious. A closer check could also be made on medication and special treatments of persons already under a doctor's care.

We have discussed taking our services into the community more. An elaborate mobile booth system was tried in the beginning and failed, probably due to the areas serviced, such as hockey games and labor center meetings. We think personal "door-knocking" and availability in other low-income and public housing areas may help us to reach old age pensioners, those on welfare, single parent families, and so on.

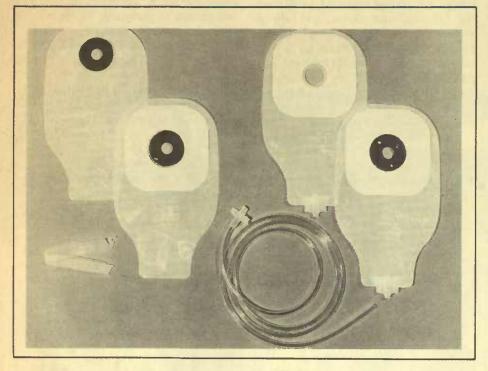
# Summary

Nurses are often task oriented, and some of us found it difficult at first to remain relatively stationary for a seven-hour shift in a booth. But the obvious needs of the community for an information clearinghouse and the genuine health concerns of clients make this project both satisfying and challenging for the staff.

Questions at the booths at first were quite superficial, but now we find we are able to do more intensive health teaching and counseling.

The Cumberland Street office provides a social contact for some of the "regulars." Frequently these people are lonely, frustrated, and suspicious of existing agencies. We have made an attempt to help them help themselves by providing correct, factual, simplified knowledge in a setting they can relate to and in a manner that maintains their self-worth and dignity.

# new products



Ileostomy Bags For Children



Gauze Drainage Dressings

lleostomy bags for children

Hollister Limited has introduced nineinch urostomy bags and nine-inch drainable stoma bags, which are shaped to fit a child's body to provide maximum capacity and minimum bulk. Built-in Karaya seal rings help prevent skin excoriation and provide a comfortable cushion for the skin, stoma, and suture lines during healing.

According to Hollister, both of these disposable appliances have been shown to be much more resistant to odor penetration than polyethylene bags. A detachable drain tube, adaptable to any hospital-used end collector, is provided with each box of urostomy bags.

For further information, write to Hollister Limited, 332 Consumers Road, Willowdale, Ontario.

Gauze drainage dressings

Aquaflo gauze drainage dressings, available from Chesebrough-Pond's Inc., "compel drainage of wound secretion through the capillarity of its wettable petrolatum impregnant."

Aquaflo gauze's impregnant retains the lubricating quality of petrolatum, but instead of repelling aqueous material, propels secretions through the gauze into an absorbent layer where it is stored away from the wound. Since the impregnant is insoluble to water, the petrolatum is not dissolved or carried away by wound secretions, ensuring long-lasting lubricity. The dressing's fine mesh gauze prevents entrapment by granulations, thus eliminating the need for frequent dressing changes.

These dressings are available in two sizes—1 inch x 8 inches and 3 inches x 9 inches. These are individually packaged in sterile, foil envelopes. For further information, write to Hospital Products Division, Chesebrough-Pond's (Canada) Ltd., 150 Bullock Dr., Markham, Ontario.

Oral antibiotic, Rimactane

CIBA Pharmaceuticals, a division of Ciba-Geigy Canada Ltd., has brought to Canada a new oral antibiotic, Rimactane, which has proved to be highly effective in the treatment of pulmonary tuberculosis when it is used as the primary component in combination with other drugs.



# LA CROSS HAS BEAUTIFUL IDEAS

There's more to La Cross than pro-fessional good looks. Count on La Cross for comfort, long wear and easy care fabrics. La Cross . . . the name to trust for value in quality hursing fashions.

Front hidden zipper. Action sleeve gussets.

RIBBED KNIT JERSEY TRICOT

Style 2719 Retails about \$17.98

**SIZES 5-17** 

This and other styles available at uniform shops and department stores across Canada.



PROFESSIONAL UNIFORMS



LA CROSS CATALOGUE FOR '73.

Return to: La Cross Uniform Corp., 4530 Clark St., Montreal, Que.

- Yes, I am interested in receiving my FREE fashion-filled catalogue for '73.
- Please send address of nearest store where I can purchase La Cross uniforms.

NAME

ADDRESS

CITY

CN 3-73

# names

# CNA Honors Jean Leask On Her Retirement



Photographed in the foyer of CNA House during the January 11-12 meeting of the CNA directors are Jean Leask, retiring national director of the Victorian Order of Nurses, center, as she accepts a copy of The Leaf and the Lamp from Marguerite Schumacher, president of the CNA board of directors, right. Looking on is Ada McEwan, incoming national director of the VON, left. Ms. Leask admitted that retirement would mean leaving behind a great deal of her life. She expressed her personal views to those attending the meeting: "Nursing has been rewarding, not only in the field of nursing itself, but in my relationships with colleagues and associates. If I had my life to live over again, I would still be a nurse... but a nurse working in a broader concept." Regarding the profession, she said, "We have been at many crossroads. We must decide if we are to continue in nursing, to expand our field... or whether we are to become something else, such as a nurse leaning to the medical profession. We should remain nurses, and still give care and take on other projects. This is exciting," said the former national director of the VON.

At the end of January 1973, Jean Leask retired as national director of the Victorian Order of Nurses for Canada. She has been succeeded by Ada Mc-Ewen.

Born in Moose Jaw, Saskatchewan, Ms. Leask received a bachelor of arts degree at the University of Toronto before entering its school of nursing. On graduation from the university school of nursing, she joined the VON as a staff nurse in the Toronto branch. She later was nurse-in-charge of the Regina branch and, following a traveling fellowship from the Rockfeller Foundation, was supervisor and assistant district director in Toronto.

In 1952, she went to the University of Chicago, where she obtained a master of arts degree, majoring in public health nursing administration. Returning to Toronto in 1953, she was a staff nurse and assistant director in the nursing division of the Toronto department of public health. She rejoined the VON in 1960 as national director.

In 1969, Ms. Leask received the R.D. Defries Award from the Canadian Public Health Association for her outstanding contribution in public health. She has been active in many associations, including the Canadian Nurses' Association, Canadian Public Health Association, the national nursing com-

mittee of the Canadian Red Cross, and the Canadian Council on Social Development. In 1965, she was invested as Officer Sister in the Order of St. John, and in 1968, was appointed a member of the commission to study the structure of the Canadian Public Health Association.

The new national director of the VON, Ada McEwen, was born in Maxville, Ontario. She is a graduate of the Montreal General Hospital school of nursing and McGill University. She holds an M.P.H. degree in health administration from the School of Public Health, University of North

Carolina, Chapel Hill.

Before joining the VON in 1950, Ms. McEwen worked at the Montreal General Hospital and the Trail-Tadanac Hospital in Trail, British Columbia. She has had a varied career with the VON as staff nurse; nurse-in-charge and district director of Orillia, Ontario, Edmonton, Alberta, and Windsor, Ontario branches; and regional director on the national office staff in Ottawa. In 1967, Ms. McEwen left the VON to become executive director of the home care program for Metropolitan Toronto.

Ms. McEwen assumed her new duties as national director in February 1973. She is the eleventh national director of the VON, which is marking its 75th anniversary this year.



Merren Tardivelle (B.A., U. of Manitoba, Winnipeg), has been appointed editor of the *International Nursing Review*. She has been acting editor of the *Review* for the past year.

A native of Canada, Ms. Tardivelle joined the staff of the International Council of Nurses in 1966. Since then she has been involved in various capacities with ICN publications, particularly the newsletter ICN Calling. In 1971, the Council of National Representatives voted that the newsletter be combined with the Review.

Ms. Tardivelle says that plans for the publication include emphasizing the specific programs, activities, and achievements of ICN and its member associations. The *Review* will continue

to cover trends in nursing education, practice, service, and social changes affecting the welfare of nurses. It will show how the nurse's practice is developing to meet health care needs in different settings and will report on activities of other international organizations relating to nurses and health.

Iris Monardez, a nurse from Chile, joined the staff of the International Council of Nurses in Geneva in September 1972. She succeeds Birgit Tauber, who has returned to Denmark.

Before this appointment, Ms. Monardez was director of the department of nursing at the University of Chile in Valparaiso, where she taught nursing administration, social foundations in nursing, and the history of nursing. She was active in the university's reform movement, which began in 1969. She has also held the positions of assistant director and director of the Carlos Van Buren School of Nursing in Valparaiso.

She obtained a diploma in hospital nursing and public health nursing from the University of Chile in Santiago, and has taken courses in nursing education and fundamentals of administration and research. In the United States, she has taken courses at the master's level in public health nursing at Western Reserve University in Cleveland, Ohio, and in nursing education at Teachers College, Columbia University, New York.

Ms. Monardez has served as president, secretary, and treasurer of the Chilean Nurses' Association. In addition, she has been elected to office in two other national women's groups in Chile. She has led seminars on nursing education in Chile and acted as a WHO nurse adviser for a six-month project in Venezuela.

The Volunteer Nursing Services Bursary Committee of the Ontario Division, Canadian Red Cross Society, has awarded Elizabeth Lorraine Holder the \$1,000 continuing education bursary for 1972-73. She will use the bursary in her studies toward a Master of Science degree in nursing at the University of Toronto.

This bursary is awarded annually to an Ontario registered nurse to continue studies at the degree level. Candidates are selected on the basis of training, experience, leadership qualities, and anticipated contribution to nursing in Ontario.

Ms. Holder, a native of New Brunswick, received her nursing diploma from St. John General Hospital in 1954. Since then she has earned certificates in psychiatric nursing and a

**MARCH 1973** 

Bachelor of Science in Nursing degree from the University of Toronto.

She has had nursing experience in the St. John Hospital, New Brunswick; the Montreal Neurological Institute; and Sunnybrook Hospital, Toronto. Ms. Holder spent the past two years as an instructor at the Scarborough Regional School of Nursing.

The Alberta Association of Registered Nurses has appointed Robert R. Donahue as public relations officer. He succeeds Donald LaBelle.



A native of Alberta, Mr. Donahue has worked in Canada and Dublin, Ireland. For the past four years, he was public relations officer for the Civil Service Association of Alberta. He has also spent

six years working for Canadian daily newspapers and has done public relations and advertising work in Canada and Ireland.



Yvette Loiselle, Montreal, was recently appointed superintendent - i n chief of the Saint John Ambulance Brigade in Canada. Her association with the Order of St. John began in 1944, when

she joined the Brigade as a nursing member. In 1956 she was awarded the Service Medal of the Order of St. John, and in 1970 she received the Dame of Grace, Order of St. John.

WILL YOU PASS YOUR BOARDS?

PRE LEST Unique study guide available to nurses

# EVALUATE YOUR PREPARATION

- High quality, professional examination patterned after official examination
- Specially designed for nurses preparing for
- Completely revised this year
- Spotlight your weak areas Gives feel of what actual exam is like
- Take PRETEST, return answer sheets for confidential computer scored evaluation on national basis
- Answers and complete references provided

PreTest(s) for nurses @ \$10 each (Conn. residents add 7% state sales tax) For Air Mail delivery, add \$1.00 per PreTest

in U.S. and \$1.50	per Pre l'est	in Canada.
Name (print)		Year
Address		
City	State	Zip
PreTest Service In		

Ms. Loiselle, who has held various positions in employee relations in Montreal, has been employee relations assistant for Celanese Canada Limited in Montreal since 1967.

Joyce Nevitt (B.Sc.N., McMaster U., Hamilton, Ont.; cert. P.H.N., U. of Toronto; M.A., Teachers College, Columbia U., New York) was elected a fellow of the Royal Society of Health in Great Britain in August 1972. At the same time, she received a citation in the Dictionary of International Biographies. The citation reads: "For advancing nursing education in Newfoundland.



Since 1965, Ms. Nevitt has been director of the school of nursing at Memorial University of Newfoundland in St. John's. From 1963 to 1965, she was assistant professor and assistant

head, public health nursing department, at Wayne State University in Detroit, Michigan. She has also been a lecturer in public health nursing at the University of Western Ontario in London, a public health nurse in Ontario, and a head nurse and instructor at Toronto

Western Hospital.

Active in the Association of Registered Nurses of Newfoundland, Ms. Nevitt has been a chapter president, first and second vice-president, member of the board of examiners, and a member and chairman of various committees. In 1966 she was a member of the board of the Victorian Order of Nurses and in 1971 was a branch president in the Canadian Public Health Association.

Ms. Nevitt was a Canadian Nurses' Foundation Fellow from 1962 to 1963. She has published in a number of journals, including The Canadian Nurse.

In 1972 the Saskatchewan Registered Nurses' Association awarded \$7,700 in bursaries to eight Saskatchewan nurses for postgraduate studies.

Judy L. Tooley, Saskatoon, received \$850 to complete studies for a degree in nursing at the University of Saskatchewan, Saskatoon campus. She is a 1965 graduate of the university's school of nursing, Saskatoon.

Jean Moneo, Saskatoon, received \$1,000 to complete studies for a doctorate in sociology at the University of Florida in Gainsville. She is a 1968 graduate of the university's school of nursing, Saskatoon.

Marie Darichuk, Saskatoon, a 1963 graduate of St. Paul's Hospital school

# names

of nursing in Saskatoon, received \$1,000. She is completing studies for a degree in nursing at the university's Saskatoon campus.

MaryBelle Denis, Saskatoon, received \$1,000 to complete studies for a degree in nursing at the Saskatoon campus. She is a 1968 graduate of the St. Elizabeth Hospital school of nursing in Humboldt, Saskatchewan.

Lorine Strobbe, Saskatoon, received \$1,000 to complete studies for a degree in nursing at the Saskatoon campus. She is a 1952 graduate of the Miscricordia Hospital school of nursing in Edmonton, Alberta.

Leah Ann Woodard, Regina, received \$850 to complete studies for a degree in nursing at the University of Manitoba. She is a 1965 graduate of the Regina Grey Nuns' Hospital school of nursing.

Ann Collinson, Switt Current, received \$1,000 to complete studies for a degree in nursing at McGill University in Montreal. She is a 1970 graduate of Foothills General Hospital school of nursing in Calgary, Alberta.

Roberta Arens, Moose Jaw, received \$1,000 to complete studies for a degree in education at the Regina campus, University of Saskatchewan. She is a 1964 graduate of Moose Jaw Union Hospital school of nursing.

Dr. Muriel Uprichard and Alice J. Baumgart have been elected to the senate of the University of British Columbia for a three-year period. They were chosen by a general election among the faculty members of the university. The senate is responsible for the curriculum, instruction, and education offered by the university.

Dr. Uprichard (B.A., Queen's U., Kingston, Ont.; M.A., Smith College, Northampton, Mass.; Ph.D., U. of London Institute of Education; post-doctoral studies in public health, U. of Michigan, Ann Arbor) is director of the UBC school of nursing. Before she joined the university faculty, she was senior lecturer in nursing and associate research psychologist at the University of California in Los Angeles. She has also been associate professor in the school of nursing at the University of Toronto.

As consultant to the Royal Commission on Health Services in Canada from 1964 to 1965, Dr. Uprichard was responsible for the section of the report that dealt with the improvement of patient care by more effective utiliza-

# English Visitor Meets Clinical Specialists At CNA House



After six weeks in the United States on a World Health Organization fellowship, Marjorie G. Gardener, *right*, visited the Canadian Nurses' Association headquarters in December 1972 during an additional three-week study tour of Canada. As principal nursing officer at the Joint Board of Clinical Nursing Studies in England, Ms. Gardener was interested in studying basic clinical education and the role of the clinical nurse specialist in Canada. At CNA House, she met two CNA directors, Roberta Coutts, *left*, and Denise Lalancette, to discuss their work as clinical specialists. Ms. Coutts is a head nurse at The Montreal General Hospital and Ms. Lalancette is a clinical nurse, maternal and child care, University of Sherbrooke Clinic, Sherbrooke, Que.

tion of nurses. Her views on "The cducation of nurses," which she presented in the Marion Woodward Lecture in Vancouver in November 1971, were published in *The Canadian Nurse* in June 1972.

Alice Baumgart (B.S.N., U. of British Columbia; M.Sc. (Appl.), McGill U.) is an associate professor in the UBC school of nursing, where she has held the positions of clinical instructor and assistant professor. She has also worked as a staff nurse at the University of Oregon Medical School Hospital.

Ms. Baumgart has been an active member of the Registered Nurses' Association of British Columbia and the Canadian Nurses' Association. She was chairman of the CNA standing committee on nurs-

ing education from 1970 to 1972. In 1970, she was the first Canadian nurse to be awarded a Milbank Faculty Associate Fellowship. She has contributed a number of articles to *The Canadian Nurse*.

Avis Henry (R.N., MacClesfield General H., Cheshire, England; S.C.M., Queen Elizabeth Maternity H., Birmingham, England; dipl. PHN and B.Sc.N., U. of Ottawa) has been named director of nursing for the Firestone Plantations Company nursing service in Liberia, West Africa.



Ms. Henry has had experience as a staff nurse and district midwife in England. She has held a number of positions in Canada: general duty nurse at the Oshawa G e n e r a l Hospital in Oshawa,

Ontario; public health nurse with the Victorian Order of Nurses in Ottawa and Toronto; and teacher at St. Joseph's School of Nursing in Toronto and at the Scarborough Regional School of Nursing in Scarborough, Ontario.

Lakehead University in Thunder Bay, Ontario, has announced the following appointments in the school of nursing.

Marjorie A. Wallington (R.N., Oshawa General H., Oshawa, Ont.; B.Sc.N.,

**MARCH 1973** 

U. of Western Ontario, London; M.Sc.N., Boston U.) is an assistant

professor.

From 1969 to 1972, Ms. Wallington was an adviser in nursing in the mental health division, Ontario department of health. Her major interests there included developing effective patient programs, developing the role of the psychiatric nurse as a therapeutic agent within these programs, staff utilization, and staff development.

Her past experience has also included working in nursing service and nursing education at the Guelph General Hospital in Guelph, Ontario; teaching at the Toronto General Hospital school of nursing; and developing the role of clinical specialist at the Toronto Gen-

eral Hospital.

Sharon Oliver (R.N., The Montreal General H.; B.N., McGill U.) is a lecturer at Lakehead University school of nursing. She has had experience working as a public health nurse with the Victorian Order of Nurses in Montreal, as a classroom and clinical instructor at The Royal Edward Chest Hospital in Montreal, as a public health nurse with the Nova Scotia department of public health in Kings County, and as a lecturer in public health nursing at Mount Saint Vincent University in Halifax.

Victoria Strang (R.N., St. Boniface General H., St. Boniface, Manitoba; B.N., U. of Manitoba) is a clinical assistant at Lakehead University. She has worked as a general duty nurse at the St. Boniface General Hospital in Manitoba and as a lecturer at the University of Manitoba school of nursing from 1967 to 1971. She has served on the nursing education committee of the Manitoba Association of Register-

ed Nurses.

William Alexander Ayotte (R.N., Regina Grey Nuns' H., Regina, Sask.; Reg. Psych. Nurse, Sask. Training School, Moose Jaw, Sask; dipl. nursing serv. admin., U. of Saskatchewan, Saskatoon) has been appointed assistant director of nursing at Prince George Regional Hospital in Prince George, British

Mr. Ayotte has had varied experience as a registered psychiatric nurse at the Saskatchewan Training School in Moose Jaw; as an operating room nurse at the Regina Grey Nuns' Hospital and at Penticton General Hospital in Penticton, British Columbia; and as a head nurse of a psychiatric unit and hospital supervisor at the Vernon Jubilee Hospital in Vernon, British Columbia.

He is an active member of the Registered Nurses' Association of British

Columbia.



Lorraine G.J. Row-(R.N., The General H. of Port Thunder Arthur, Bay, Ont.; dipl. nursing educ., U. of Western Ontario, London; B.Sc.N., Lakehead U., Thunder Bay) has been

named curriculim coordinator at Lakehead Regional School of Nursing in

Thunder Bay, Ontario.

Ms. Rowson has worked as a staff nurse and teacher at The General Hospital of Port Arthur in Thunder Bay. From 1968 to 1972 she was a teacher at Lakehead Regional School of Nurs-

Helen L. Field has been appointed acting director of the St. Clair Regional school of nursing in Sarnia, Ontario.



Ms. Field (R.N., Brantford General H., Brantford, Ont.; dipl. teaching and admin., U. of Toronto) was a nurseteacher for three years at St. Clair Regional school of nursing. She has

also worked at the Brantford General Hospital as a general duty and head nurse, and as an assistant director of nursing; and at the Sarnia General Hospital as an obstetrical head nurse, nurse teacher, and assistant director of nursing education.

She is a member of the Registered Nurses' Association of Ontario and was president of the Brantford General Hospital Alumnae Association for three years.

Hildy Neufeld (R.N., Winnipeg General H.; B.N., McGill U., Montreal) has been named assistant director, St. Boniface General Hospital, School of Nursing, St. Boniface, Manitoba. She was previously coordinator of continuing education for the Manitoba Association of Registered Nurses.



Ms. Neufeld has held various positions in Winnipeg and Montreal. At the Winnipeg General Hospital School of Nursing, she was a teacher and assistant director, inservice education. At

the Montreal General Hospital, she was a teacher from 1965 to 1971. She did general duty nursing at the Montreal General and the Children's Hospital of Winnipeg.

From 1970 to 1971, she was a member of the nursing education committee of the Association of Nurses of the Province of Ouebec.

Raymond M. Thompson (R.N., Victoria General H., Halifax; B.Sc.N., and M.Sc.N., U. of Western Ontario, London) has been appointed assistant professor in the school of nursing at the University of British Columbia.



Mr. Thompson has worked as a general duty nurse at the Nova Scotia Hospital in Dartmouth, at the Toronto General Hospital, and at the Wellesley Hospital in Toronto. From 1967 to 1969,

he was an instructor in medical nursing at the Wellesley school of nursing.

Patricia Hay has been appointed director of nursing service at Women's College Hospital in Toronto.



A graduate of St. John General Hospital, Saint John, N.B., she has held various positions there in nursing service. She has also had experience at the Boston Lying-In Hospital, Boston,

Massachusetts, U.S.A.

Ms. Hay obtained a diploma in nursing unit administration at the University of Toronto, a bachelor of nursing at McGill University, and a master of health service administration at the University of Alberta.

Peggy Saunders (R.N., Calgary General H., Calgary, Alta.; B.N. and M.N., McGill U., Montreal) has been appointed an assistant professor at the University of British Columbia.



Ms. Saunders worked as a general duty nurse in hospitals in England, Australia, and New Zealand from 1949 to 1952. In Canada, she has worked as an office and OR nurse in Alberta; assistant

head nurse at the Vancouver General Hospital, British Columbia; nursing instructor at Municipal Hospital in Medicine Hat, Alberta; nursing instructor at Holy Cross Hospital and Foothills Hospital in Calgary, Alberta; and nursing lecturer at the University of Toronto and Red Deer College, Red Deer, Alberta.

# research abstracts

The following are abstracts of studies selected from the Canadian Nurses' Association Repository Collection of Nursing Studies. Abstract manuscripts are prepared by the authors.

Steels, Marilyn Margaret. Perceptual style and the adaptation of the aged to the hospital environment. Cleveland, Ohio, 1972. Thesis (M.S.Nurs.) Case Western Reserve U.

Hospitalization involves a loss of familiar environmental cues and exposure to new stimuli. Therefore, adaptation is required of all persons admitted to hospitals. Several studies have focused on mortality as an indicator of adaptation in aged persons admitted to institutions or otherwise relocated. In contrast, the present study examined the relationship between functional measures of adaptation and fielddependence-independence in rehabilitation hospital patients.

Field-dependence-independence was defined in terms of a subject's ability to perceive items as separate from their context. Measures of adaptation used were: 1. actual independence in activities of daily living; 2. discrepancy between actual and potential independence in activities of daily living; 3. mental status; 4. morale; 5. psychophysiological behavior; and 6. social

involvement.

Data were obtained from 17 female and 13 male subjects 65 years of age and older, and from nurses responsible for their care in a rehabilitation hospital. All interviews were conducted during the second or third week of the subjects'

hospitalization.

Degree of field-independence and level of morale were assessed from a subject's performance on the Children's Embedded Figures Test and his responses to the Kutner Morale Scale. A modification of the Katz Index of Independence in Activities of Daily Living was used to obtain a nurse's evaluation of each subject's performance in activities of daily living. Mental status, psychophysiological behavior, and social involvement were assesed from nurses' ratings of subject behavior on scales developed by the investi-

The hypotheses were tested by means

of correlation and difference-testing techniques. The Spearman rank order correlation, the Mann-Whitney U test, and the Kruskal-Wallis one-way analysis of variance were used. Significance was set at the .05 level.

In this subject population, a greater degree of field-independence was significantly associated with relative independence in activities of daily living, optimal performance in activities of daily living, relatively normal mental status, higher levels of morale, relatively normal psychophysiological behavior, and greater social involvement. Additional analyses revealed that degree of field-independence was not associated with the age or sex of the subjects.

Of the variables used in testing the study's hypotheses, only independence in activities of daily living was affected by the presence of diagnosed cerebrovascular disease. None of these variables was significantly affected by the number of previous hospitaliza-

tions recalled by the subjects.

These findings indicate a relationship between an aged person's degree of field-independence and his functioning in the hospital environment. Therefore, hospital personnel should attempt to manipulate the hospital environment to support the functioning of field-dependent aged patients.

Checkley, Kenneth Lloyd. The influence of a human relations laboratory on the effectiveness of third-year psychiatric nurses. Edmonton, Alta., 1971. Thesis (Ph.D.) U. of Alberta.

This study was designed to determine the influence of an intensive shortterm residential human relations laboratory experience on the effectiveness of third-year psychiatric nursing students' work with selected longterm hospitalized male psychiatric

patients.

Twelve female members of the third-year class of psychiatric nursing students at the Alberta Hospital, Edmonton, were selected for participation in the project. Two groups of six each were formed, having been matched only on the criterion of nursing aptitude as measured by the Nursing Aptitude Test developed by Thelma Hunt. The experimental group participated in a short-term human relations laboratory experience, while the control group were subjected to a placebo form of treatment. Prior to this treatment period, and again following it, each sutdent completed the following instruments: The California Psychological Inventory, the Orientation Inventory and the Personal Orien-

tation Inventory.

Following this aspect of the research project, three pairs of psychiatric nursing students were selected from the experimental group and three pairs from the control group. Each pair met daily for one hour with a selected group of long-term male patients. Prior to the commencement of the group sessions on the ward, and again following their conclusion some four weeks later, each patient was assessed by a member of the permanent nursing staff using the following instruments: The Hospital Adjustment Scale, The MACC Behavioral Adjustment Scale and the Psychotic Reaction Profile.

The data obtained were compared by the use of a one-way multivariate analysis and Hotelling's T2 statistic. There were no significant differences noted at the desired level (.05). The student nurses' interactions during their involvement with the patients in the group to which they were assigned were observed for ten-minute segments five times on the fifth, elevseventeenth, twenty-second and twenty-seventh day of the four-

These data were recorded by use of Bale's Interaction Record and were subjected to a two-factor analysis of variance with repeated measures on factor 'B'. The Analysis revealed that the experimental group responded significantly more positively, interacted more with their patients, and employed fewer negative comments than did

the control group.

week research period.

This study did not reveal any significant changes in the personality of the students participating in the research treatment. Neither did it reveal any changes in the behavioral adjustments of the patients involved. However, it did reveal significant differences in the manner in which the experimental subjects interacted with their patients as compared with the interaction of the control subjects with their patients.

# books

Key Concepts for the Study and Practice of Nursing by Marjorie L. Byrne and Lida F. Thompson. 101 pages. Saint Louis, Mosby, 1972.

Reviewed by Jennie M. Weir, Associate Professor, Faculty of Nursing, University of Toronto, Toronto, Ontario.

"The study of the natural and behavioral science, which is an integral part of nursing education, provides many valuable but isolated thoeries and concepts that are relevant to man's functioning as a united whole. The purpose of this book is to provide a perspective and framework for the synthesis and extension of these ideas in order to develop a greater understanding of man when he is faced with a threat of illness.

"The nursing profession as a whole has not aligned itself solidly behind any one frame of reference for nursing practice. Therefore our rationale for the perspective presented in this book has been made as explicit as possible to enable the reader to compare and contrast our approach with others so that individuals can identify for themselves the general framework they choose to utilize as a basis for their own nursing practice."

The authors proceed to give a conceptual framework in a clear and logical fashion. The presentation of the concepts are well illustrated with diagrams and examples of behavior.

Observation is recognized as a key skill and a word is coined to describe what the nurse is observing, "organismic behavior," defined as those observable features and actions that reflect man's functioning as a unified whole within the environment in which he exists (internal and external). Factors which affect man's ability to adapt to his environment are presented and summarized well at the end of the chapters.

The final chapter, "A Framework for Nursing Practice," "directs attention to the primary or central reason for the nursing profession's existence as a separate professional entity: the role of assisting the patient or potential patient to maximize his adaptive processes in daily living so that he will be able to function as effectively and efficiently as possible and to actualize

himself according to his nature."

The book met its purposes well. It is readable and can be recommended for first-year baccalaureate students to help with self-teaching and for any faculty member interested in developing a curriculum for first-year students that includes concepts that can be applied in any clinical setting.

Principles of Medicine, 5ed., by James Verney Cable. 743 pages. Christchurch, New Zealand, N.M. Peryer Ltd., 1972.

Reviewed by Margaret Arklie, Lecturer, School of Nursing, Dalhousie University, Halifax, Nova Scotia.

In the fifth edition, the author highlights many recent advances in medical knowledge, including sections on immunity, autoimmune disorders, heredity and disease, organ transplantation, and milliequivalent quantities.

His style of writing simplifies these complex subjects. Examples are frequent and specific, illustrations are helpful, and excellent summaries are provided. The chapter, entitled "The Body Fluids," is particularly well written.

The author acknowledges the contribution of a nurse, June Gordon-Crosby, in the preparation of this up-to-date textbook.

Although this textbook was written specifically for the nurses of New Zealand, I believe it would be a valuable addition to any nursing library. It presents modern concepts clearly and concisely.

Early Care of the Injured Patient by The Committee on Trauma, American College of Surgeons. 441 pages. Toronto, Saunders, 1972.

Reviewed by Mary G. Matiko, Lecturer, School of Nursing, University of Saskatchewan, Saskatoon, Saskatchewan.

The purpose of this manual is well stated in the preface: "to improve the quality of care of the injured by providing a ready reference for physicians in the care of patients in the hospital." This book could also be a valuable quick

reference for nurses, physicians' aides, and all students in the health care professions.

The comprehensive list of injuries is logically organized, with concise, clear, uncomplicated explanations. Many helpful diagrams are used to illustrate the treatment, eliminating the need for detailed explanations. The index is helpful in finding specific subjects.

Some of the subjects in the manual are cardiopulmonary resuscitation, shock, infection, bites, general principles of fracture treatment, legal aspects, management of mass casualties, and common injuries to specific body systems and parts. There is a list of references for the legal aspects, though unfortunately a bibliography was not included in this manual.

This book would be most useful in emergency departments, first-aid stations, and centers where nurses are working independently and medical consultation is not readily available.

The Development of the Infant and Young Child, 5ed., by R.S. Illingworth. 377 pages. London, England, Churchill Livingstone, 1972. Canadian Agent: Longmans, Don Mills, Ontario.

Reviewed by Ruth Elliott, Lecturer, Pediatric Nursing, University of British Columbia, Vancouver, B.C.

To reduce the vast quantity of available literature and information about developmental assessment and normal development of infants and children, the author has updated and revised his book, originally published in 1960. He emphasizes the importance of a thorough understanding of the normal child and his development, before systematic assessment and diagnosis of children with physical, mental, or sensory problems can be achieved.

The author states the difficulties involved in developmental assessment and the problems inherent in correlating assessments in infancy with intelligence tests in older children or to success in later life. Accurate analysis of inaccurate data is a mistake to be avoided

The need for knowledge of child

# books

development by the physician is treated pragmatically. Some reasons given are: children to be adopted should be accurately assessed prior to placement so adoptive parents are spared the disappointment of receiving a child later to be diagnosed as having some physical or mental handicap; children who are presented to the doctor's office or clinic may suggest the presence of a not-toowell defined symptom, often escaping accurate diagnosis and follow-up treatment.

Also, the physician is often the person to give advice about behavior problems encountered in the growing-up process of both normal children and

those with handicaps.

The author reviews extensively the history and research related to developmental testing, and deals with the major categories of developmental problems' causation — prenatal, perinatal, and environmental factors.

His assessment of the newborn (normal, premature, and handicapped), with special reference to reflexes and reactions, is meticulously done. This section of the book is enhanced by photographs illustrating the infant responses discussed.

The author deals with child development in other areas such as motor, speech, vision, hearing, understanding, and so on, and relates this to problems of physical and mental subnormality.

The research the author quotes is, indeed, extensive and lengthy bibliographies appear at the end of each chapter. However, the book lacks reference to much of the current research either completed or in progress at well-known North American centers devoted to child development. Perhaps in his attempt to be concise, the author has overlooked the new knowledge emerging from excellent studies both in Canada and the United States.

Since one of the great concerns of this decade is the reformation of roles in the health care team and, in particular, the changing role of the nurse, I feel that ongoing developmental assessment, and program planning and execution for children and their families is no longer the prerogative of the physician alone. The author makes some reference to other health team members but rarely refers to the nurse as a resource for assessment, care, and follow-up.

This book is written by a physician and intended for physicians. It has

much valuable data but, in my opinion, should not be a major reference in a health sciences library.

Pregnancy, Birth and the Newborn Baby by Seymour Lawrence, Boston Children's Medical Center. 474 pages. New York, Delacorte, 1972. Canadian Agent: Fitzhenry and Whiteside, Don Mills, Ontario. Reviewed by Anne Kiss, Assistant

Reviewed by Anne Kiss, Assistant Professor, McGill University, School of Nursing, Montreal, P.Q.

This book was designed as "a comprehensive guide to pregnancy, child-birth, and the first six weeks of a baby's life," according to the jacket commentary. Experts from obstetrics, pediatrics, anthropology, social work, psychiatry, and psychology contributed to the book.

The health education department at the Boston Children's Medical center organized it as a source book for parents, with the idea that parenthood is a significant part of life, that the physical, social, and emotional aspects of reproduction affect the quality of the experience, and that knowledge related to these areas is helpful in understanding the implications of becoming a parent.

A broad view of childbearing is taken in the first section by Niles Newton and Margaret Mead; the first author points out the changes in behavior not only of the parents but significant others in relation to childbearing. The second describes changes occuring in the world, their impact on families, and the need to establish institutions that will meet the needs of childbearing women. Newton also gives documented advice that should prove extremely useful to the pregnant couple.

The information in the sections on pregnancy; birth, including labor and delivery; and on the baby were well written, informative, and up-to-date. I would wonder if the pregnant couple might not learn more than they really cared to know about complications of pregnancy, labor, and delivery, such as anencephaly and so on. However, if they had already heard about such problems, it could be helpful to get straightforward information.

Aspects of psychological adaptation are dealt with clearly and in a helpful way. The impact of parenthood, the growth of maternal love, and the tobe-expected conflicts, mothering responsibilities, and personal goals are discussed.

In this day of difficulty in obtaining appointments with pediatricians, some of the suggestions in the chapter, "Your Baby's Doctor," are a bit less than realistic. For example, it is suggested

that an appointment be made before the baby is born, in order that the parents and doctor get to know each other. The baby would be born before the appointment could be kept, in many cases.

There are useful chapters on infertility, abortion, and genetics, which are sources of up-to-date information. The entire book is readable.

No book can be the answer to all questions, but I feel that the young couple who copes with situations by seeking knowledge would find this a useful book. It does not replace Dr. Spock but does add some new dimensions. Also, two young pregnant friends have already asked to borrow the books, so a very small sample already expects value from it. I am sure professionals working with childbearing families would also be interested.

Understanding Electrocardiography:
Physiological and Interpretive
Concepts by Edwin G. Zalis and
Mary H. Conover. 192 pages. Saint
Louis, Mosby, 1972.
Reviewed by Patricia Styran Faculty

Reviewed by Patricia Styran, Faculty of Nursing, University of Toronto,

Toronto, Ontario.

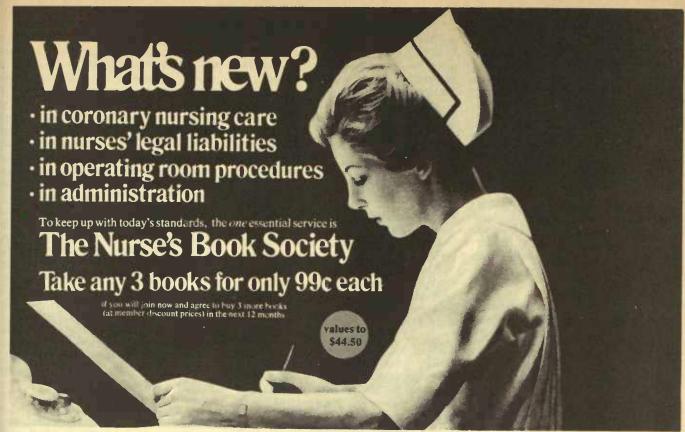
In order for the nurse in the coronary care unit to function effectively, she must be able to recognize cardiac arrhythmias quickly and accurately. Ideally this skill is the result of a working knowledge and understanding of electrocardiography. This book was written to provide knowledge and understanding for nurses, as well as for general practitioners, medical students, and paramedical personnel.

Beginning with the basic anatomy and physiology of the heart, the authors have set forth in a logical and comprehensive manner the electrophysiology of the normal heart with considerable detail on vector cardiology, axis and axis deviation, and the lead systems. Diagrams are plentiful, well labeled, and effectively used to illustrate these

The major portion of the book provides excellent coverage of arrythmias with adequate sample tracings and test tracings at the end of each chapter. One of the highlights of this book is the inclusion of much material that is not often found in such detail in many of the usual coronary care nursing textbooks.

Whole chapters are given to such topics as aberrant ventricular conduction, preexcitation, dual rhythms, fusion beats, and bundle branch blocks with detail on hemiblocks. Changes in the electrocardiogram due to area of infarction, necrosis, injury, ischemia,

(Continued on page 54)



(retail prices shown)

70160. INTENSIVE NURSING CARE, Second Edition. Frances Storlie, R.N., M.S. With Elizabeth Rambousek, R.N., M.S. and Eutha Shannon, R.N., M.S. Acute pulmonary problems...cardiac nursing... gastrointestinal crises... poisoning remedies... intensive care after obstetric surgery and complicated childbirth. Required reading for all nurses. \$10.50

48190. FAMILY THERAPY. Gerald H. Zuk, Ph.D. Offers a wealth of clinical wisdom for the nurse whose patients often present family problems. Parent-child conflicts . . . strained relations . . . techniques of family therapy. \$12,95

56130. INTERPRETATION OF DIAGNOSTIC TESTS. Jacques Wallach, M.D. Practical guide to more than 900 laboratory tests—instantly tells you, what the results of any tests signify and what normal values are in any test run on your patients. \$10.00

49390. FUNDAMENTALS OF HUMAN SEX-UALITY. Herant Katchadourian, M.D., and Donald Lunde, M.D. Two experienced sex re-searchers present a total modern guide for the health professional that covers all physical as-pects of sex (from techniques of intercourse to the rules of sex hormones). \$15.00

40570. THE CORONARY CARE UNIT. William Grace, M.D., and Victor Keyloun, M.D. Spells out the life-saving techniques, nursing methods, and organization needed in the CCU. Laced with handy tables and illustrations of electrocardio-

56361. INTRODUCTION TO OPERATING ROOM TECHNIQUE: Fourth Edition, Edna Cornelia Berry and Mary L. Kohn. Details sterile technique, positioning and draping, your duties and procedures at every stage of surgery. Filled with tips to make your performance shine in the operating room.

60430. MANUAL OF MEDICAL THERAPEUTICS: 20th Edition. Edited by Michael Rosenfeld, M.D. Step-by-step guide to management of common medical conditions. Spells out treatment procedures, drug usage, danger signs. Prized for its absolute reliability and geared to action. \$7.50

72970. PSYCHOSOCIAL NURSING. Frances Manet Carter Evans. Classifies all mental disturbances and reveals the nursing techniques that work best with unbalanced patients — from the paranoid to the woman who has just undergone a mastectomy.

\$8.95

85690. UROLOGIC NURSING. John G. Keuhnelian, M.D., F.A.C.S. and Virginia Sanders, R.N., M.A. Analyzes the structure and function of the normal urinary tract, demonstrates the methods of urologic diagnosis and covers the most often performed urologic surgery. \$9.95

63111. MODERN PERSPECTIVES IN PSYCHOOBSTETRICS. Edited by John G. Howells, M.D.
A new and different look at pregnancy and birth.
Covers material that is most timely in view of current emphasis on, and interest in, the psychosomatic aspects of both obstetrics and gynecology.
Counts as 2 of your 3 books. \$20,00

35960. BEHAVIOR AND ADAPTATION IN LATE LIFE. Edited by Ewald Busse, M.D., and Eric Pfeiffer, M.D. A virtual encyclopedia ot aging that will help you on every front in nursing the elderly. \$13.50

64980. THE NURSE'S GUIDE TO DIAGNOSTIC PROCEDURES. Ruth M. French. Everything you need to know about hundreds of diagnostic procedures—from basic urinalysis to the remarkable new scanning tests of nuclear medicine. \$7.95

64940, NURSING MANAGEMENT FOR PA-TIENT CARE. Marjorie Beyers and Carole Phillips. For nurses at every level, sage advice on communicating effectively (to higher-ups and staff), planning patient care, boosting produc-tivity, and much more. \$9.50

64960. NURSING OF PEOPLE WITH CARDIO-VASCULAR PROBLEMS. Sister Catherine Armington and Helen Creighton. The latest on nursing care for every type of cardiovascular case – radical heart surgery, cor pulmonale, stroke, rheumatic fever, peripheral vascular diseases. \$9.50

67641. PEDIATRICS. Edited by Mohsen Ziai, M.D. A major, 1000-page medical guide on care of the child from prenatal stages through adolescence. Details diseases, treatment, major emergency conditions, developmental guides, and more. Softbound. \$11.50

70090, PRINCIPLES AND PRACTICE OF INTRAVENOUS THERAPY. Ada Lawrence Plumer, R.N. For the nurse who wants to specialize in this exciting field, for the staff nurse who must maintain infusions, and for all nurses who want to be ready for any emergency.

32600. ALL ABOUT ALLERGY. M. Coleman Harris, M.D., and Norman Shure, M.D. Complete guide to the causes, prevention, treatment and cure of allergic diseases. Illustrated. \$7.95

52230. HANDBOOK OF DRUG INTER-ACTIONS. Gerald Swidler. The interactions of more than 1300 drugs, telling which other drugs must be avoided with a specific drug, preferred methods of administering, danger signs to watch for. \$15.00

32160. ACUTE CORONARY CARE, Geraid H. Whipple, M.D., and Others. Comprehensively prepared by two M.D.s and three R.N.s, this handbook is the most complete and useful nursing guide to coronary care available. Tells what new techniques and tests are available, and much more.

72990 PSYCHOSOCIAL ASPECTS OF TER-MINAL CARE. Edited by Bernard Schoenberg, M.D., and Others. A host of experts show how to cope with your own anxieties, help the patient cope with his . . . new institutional arrangements . . . new psychological skills to apply. \$12.50

32450. THE AGED ILL. Dorothea Jaeger and Leo Simmons. Path-breaking study of the methods and skills needed to cope with the unique problems of the aged. Pinpoints new directions that future geriatric care will take. \$9.95

60470. MANUAL OF SURGICAL THERA-PEUTICS. Second Edition. Robert Condon, M.D., and Others. Step-by-step guide to pre- and post-operative care, emergencies, recovery prob-lems, drugs, and every other aspect of surgical-patient care. Spiral-bound and action oriented.

- MEMBERSHIP APPLICATION =	r
----------------------------	---

The Nurse's Book Society Riverside, New Jersey 08075

6-10U

Upon acceptance of this order, please enroll me as a member and send me the three books I have indicated. Bill me only 99c each, plus postage and handling. If not delighted, I will return all books within ten days and this membership will be cancelled. As a member, I need accept only three more selections during the next 12 months at reduced member prices, plus postage and handling. Savings range up to 30% and occasionally even more.

to 30% and occasionally even more.

I understand that I will receive free advance Reviews which fully describe each month's Main Selection and Alternates. If I wish the Main Selection, I need do nothing and it will be sent automatically. If I prefer an Alternate—or no book at all—I need only return the convenient reply card you send me by the date specified. Send no money. Members are billed when books arrive.

3 books for 99c each. (write in numbers)
Some expensive books count as 2 choices.
Name
Address
CityStateZip
Book selections purchased for professional pur- poses may be a tax-deductible expense. (Offer
good in Continental U.S. and Canada only. Prices slightly higher in Canada.)

# books

(Continued from page 52)

hypertrophy, drugs, and electrolytes are considered and well depicted. Valuable content on pacemakers and electrical hazards of ECG monitoring is included.

This book is perhaps a bit advanced for a beginning graduate nurse in the coronary care unit. For the nurse who is experienced and is keen to increase her knowledge and understanding of electrocardiography, this book is excellent.

The Cardiac Patient: A Comprehensive Approach (Saunders Monographs in Clinical Nursing — 2) by Richard G. Sanderson. 548 pages. Toronto, Saunders, 1972

Reviewed by Dorothy V. Clevely, Nurse-in-Charge, Intensive Coronary Care Unit, Shaughnessy Hospital, Vancouver, B.C.

The author's objective is to provide the cardiac nurse, medical and surgical, with a more thorough understanding of heart disease in its many forms, of the processes underlying these conditions, and the therapeutic and diagnostic techniques used in the management of the cardiac patient. He has a logical approach; starting with detailed embryology, anatomy, and physiology of the heart, he proceeds through the medical, surgical, and nursing aspects of care of the cardiac patient.

Many cardiac conditions are dis-cussed, including congestive failure, valvular heart disease, pericarditis, and myocardial infarction, each with the etiology, clinical manifestations, treat-

ment, and prognosis.

Of particular interest is the chapter dealing with closed and open heart surgery. The procedures are described in detail and are well illustrated. Conditions for which surgery is indicated are briefly outlined, and the complications that may occur are described in greater detail. Also discussed in this chapter is the heart-lung machine, its use and function in open heart surgery.

The nursing aspect is well presented and includes the systematic assessment of patients' conditions, the observation, interpretation, and portent of cardiae arrhythmias, and of the therapy that may be used to treat or control

Specialized equipment used in intensive care units is mentioned briefly to point out its uses, limitations, and the problems frequently encountered.

There is an excellent chapter dealing

with electrocardiography, as well as chapters on cardiac drugs, respiratory care of the cardiac patient, cardiopulmonary resuscitation, and diagnostic techniques. In the latter, there is an excellent discussion of cardiac catheter-

This is a book that should prove of value not only to nurses in intensive cardiac care units, but also to those providing all other phases of care for the cardiac patient.

Parents and Children in the Hospital: The Family's Role in Pediatrics by Carol B. Hardgrove and Rosemary B. Dawson. 276 pages. Boston, Little, Brown, 1972. Canadian Agent: Lippincott, Toronto.

Reviewed by Mona Callin, Nursing Instructor, Dawson College, Mont-

real, Quebec.

During the last three decades, there has been a growing awareness among professional people of the importance of meeting the emotional and developmental needs of young children in

hospital.

The authors' interest in the wellbeing of preschool children and their professional experience clearly indicated the need for more people to understand children's reactions to hospitalization. So they undertook a research project to discover what new and innovative programs were currently being carried out by hospitals that were known to have embarked on policies stressing the emotional and developmental health of children.

The question of the family's role in pediatrics is a much discussed one about which most people working in pediatric settings have some strong

# GRAND TOUR OF EUROPE 22 DAYS

Departure July 30th from Toronto and Montreal by scheduled air to -

HOLLAND **WEST GERMANY AUSTRIA** ITALY (a week) SWITZERLAND FRANCE **ENGLAND** BELGIUM

First Class accommodation with bath, meals, air-conditioned buses.

Write for brochure to your experienced W.T.I. host -

> Reverend Harold Burgess, 4258 Bloor Street West, Etobicoke, Ontario. Tel.: 621-1706

ideas and opinions. The authors also must have ideas and opinions, but they are not evident in their book. The book is a dispassionate but extremely readable and interesting report of a research study. The authors do not challenge the views held by the reader but, through excerpts from policy statements and other documents, descriptions of situations, factual reporting of incidents, and verbatim quotations from conversations, allow the problem and the programs to speak for themselves.

The book describes programs and activities being carried out in 14 hospitals and medical centers in the United States. The sample includes university hospitals, large public institutions, and smaller community centers. Some hospitals are trying new approaches in old facilities, others have planned new buildings with the new approaches in mind, and others are quietly going on with the "old" approaches, such as Tufts-New England Medical Center's home care program, which was inaugurated in 1796.

The evidence collected in the study suggests that the persons involved in these innovative and successful programs do not hold all the usual traditional values. It appears that the success of an innovative project, such as a "mothering-in" program for premature infants, is preceded by some change in the beliefs of the persons involved about the traditional role of the hospital and its staff.

The comments of staff participating in these special programs suggest that treating the child and his family as people is rewarding. Perhaps this is because relating in more personal ways to children and their parents allows each staff member to expand his role and to be more of a person. It appears that relationships between members of the health team also change and become more rewarding.

This valuable book is of importance to all persons interested in the health

care of children.

Teaching the Mentally Retarded Child: A Family Care Approach by Kathryn

E. Barnard and Marcene L. Powell. 158 pages. Saint Louis, Mosby, 1972

Reviewed by Bernice Lovering, R.N., M.Ed., Coordinator of Staff Development, Mental Retardation Services Branch, Ontario Ministry of Health, Toronto, Ontario.

Today's trend in mental retardation is toward supporting the individual in his home and local community. To meet this objective, it is imperative that everyone participating in the development of a retarded person know the techniques used to assist them in achiev-

ing their maximum potential.

In this book, a family care approach specifically directs its concern to those techniques used to develop the potential of young children. The first portion of the book is directed toward developing within the reader an awareness of the concepts related to child development, handicapping conditions, nursing care approaches to handicapped children, and family dynamics associated with this handicap.

The second portion of the book focuses on a method for assessing the developmental and functioning level of a child. The Washington guide to promoting development in the young child is presented in its entirety. This guide treats various aspects of development, such as motor, language, disci-pline, and so on, by identifying the expected tasks from one to 52 months inclusive. Each set of expected tasks is accompanied by suggested activities that are oriented to promoting development within the specific area.

The final section is devoted to outlining principles, techniques, and suggested activities that may be used to develop motor, self-feeding, toileting, dressing, and play skills. Discipline for the young child is viewed as an educa-

tional process.

This book presents a practical approach to training mentally retarded young children. It could be used as a handbook for nurses, in particular public health nurses, parents, and paraprofessional staff in residential facilities for the retarded.

# AV aids

FILMS

☐ The following 16mm films have been placed in the National Health and Welfare Film Library, located at the Canadian Film Institute, 1762 Carling Avenue, Ottawa K2A 2H7.

Help Is (sound, color, 16mm, 16 min., 1971) deals with first-aid at the roadside (see "AV Aids," Sept. 1972,

Being (sound, color, 21 min., 1972) was produced for the Canadian Rehabilitation Council for the Disabled. It won the top award, non-scientific category, in the world-wide film competition at the World Congress of the International Society for Rehabilitation of the Disabled, held in August 1972. This film focuses on society's attitudes toward the person who has a disability.

Barnet (sound, color, 48 min., 1971)

gives a complete account of the conception, gestation, and birth of a child, using animation and photographs to tell the story of a young couple having its first baby. Accounts of pre- and postnatal care are included.

Methods of Family Planning (sound, color, 18 min., 1972) illustrates and explains rhythm, symptothermique, oral contraceptives, diaphragm, intrauterine device, chemicals, condom, vasectomy, and tubal ligation (see "AV

Aids," Sept. 1972, p.64).

Death and Mourning (sound, 60 min., 1970) is part of the series "Children in Conflict" produced for Browndale, with the cooperation of the CBC. The films communicate the feelings and experiences of the children in the residential treatment program at War-

VD — Name Your Contacts (sound, color, 22 min., 1968), VD: Every Thirty Seconds (sound, color, 17 min., 1971, see "AV Aids," Dec. 1972, p. 52), and You Got What? inform young people about various aspects of veneral disease.

☐ About Conception and Contraception, produced by the National Film Board of Canada, 16mm, color, 14 minutes. Reviewed by Carol Mc-Pherson, past program officer for the International Development Research Centre, Ottawa.

This brief, animated film deals with conception and contraception in a clear, explicit fashion. The explicit and slightly amusing approach has a desensitizing effect on audiences. These factors, plus the fact that no attempt is made to deal with all aspects of family planning and contraception, result in an excellent basic teaching aid.

The direct simplicity of the film and the lack of editorializing allows the teacher to adapt his presentation to the type of audience he is dealing with.

An information sheet and poster accompany the film, which is available on loan from NFB offices.

## **FILM CATALOGS**

☐ Multimedia Catalogue for Education is a 41-page film catalog that covers filmstrips, kits, tape, and Super 8mm. This catalog, which also includes items on health, drugs, and medical careers, is available from International Tele-Film Enterprises, 221 Victoria Street, Toronto 205, Ontario.

This Is Where We Live, a four-page catalog of films on ecology suitable for students of all ages, is also available from International Tele-Film Enter-

prises.

# LITERATURE AVAILABLE

☐ Willy and the Wheeze is a new booklet available free of charge from the York-Toronto Tuberculosis & Respiratory Disease Association, 157 Willowdale Ave., Willowdale 441, Ontario. Written by Helen Barron for young asthmatic patients four to ten years old, this booklet describes the disease in a clear and simple way and tells the children how they can help control it. Asthmatic children learn from this publication that Willy can play and have fun, but if he gets tired or thinks he is going to start wheezing, he should rest.

☐ Three reports are available from the Publication Section, Canadian Council on Social Development, 55 Parkdale Ave., Ottawa, Ont. KIY

Proceedings — Canadian Conference on Day Care, June 20-23, 1971, 71p., includes the keynote address by Dr. Frederick Elkin, four responses to this address, a report on the CCSD National Day Care Study, reports and recommendations from the discussion groups, and the conference summation.

Day Care — Report of a National Study by the Canadian Council on Social Development, 1972, 133p., contains the summary of the study findings and implications, with four major



**Authorized Recruiters represents** over 40 hospitals.

> FOR INTERVIEW -COME IN OR CALL DAVID CHEN

AT ROYAL YORK HOTEL 100 FRONT STREET, TORONTO 368-2511

or send resume to:

**Professional Nurse Recruiters** 1316 Wilshire Blvd., Los Angeles, Calif. 90017 recommendations. Appendices include a summary of provincial day care legislation and a report of a survey of cam-

pus day care facilities.

The One-Parent Family, 1971, 167p., is a report of a CCSD inquiry on one-parent families in Canada, based on interviews with 113 heads of such families.

Drugs — Handle With Care is a revised edition of a popular booklet recently released by the department of health and welfare. This bilingual booklet includes updated information on drug safety cartoon illustrations. Copies are available from: Educational Services, Health Protection Branch, Department of Health and Welfare, Ottawa KIA 0L2.

☐ A number of family planning publications are available free of charge from the Family Planning Division, Department of Health and Welfare, General Purpose Building, Ottawa, Ontario. These include pamphlets and booklets written for adolescents, adults, nurses, and unwed mothers. Some are available in several languages.

# accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, except reference items, may be borrowed by CNA members, schools of nursing and other institutions. Reference (R) items (archive books and directories, almanaes and similar basic books) do not go out on loan. Theses (also R) are on Reserve and may go out on interlibrary loan

Request for loans should be made on the "Request Form for Accession List" and should be addressed to: The Library, Canadian Nurses' Association, 50, The Driveway, Ottawa, Ont. K2P

No more than three titles should be requested at any one time.

# 2 for UB

disposable medical devices developed by doctors to meet basic OB requirements



# disposable amniotic membrane perforator

Offers a better way to rupture the amniotic membrane when inducing labor. Its operative end is rounded and blunt, with a protected point. Because it is not spear-shaped, there is less likelihood of traumatizing the cervix and vaginal vault. With the AmniHook the doctor does not poke at the membrane but merely snags it. By drawing back on the instrument, he ruptures the membrane without endangering the fetus. Approximately 101/2 inches long, the unit is made of high-grade plastic. Each sterile AmniHook is individually packaged.



# quick and secure ligation of the umbilical cord

The serrated jaws of the Hollister Cord-Clamp hold the clamp firmly in place and maintain a constant pressure on the cord as it dries, eliminating the dangers of seepage. No dressings are needed. The Cord-Clamp has a wide jaw opening and contoured fingertips for easy application. To insure against opening, the Cord-Clamp has a permanent blind closure. For removal, usually after 24 hours, the clamp is cut at the hinge with the special clipper provided. The lightweight, disposable Cord-Clamp may be autoclaved or purchased in individual sterile packets.

# BOOKS AND DOCUMENTS

- 1. Abrégé de gynécologie et d'obstétrique, par Henri de Tourris et R. Henrion. Paris, Masson, 1972, 487p.
- 2, Appraising managers as managers, by Harold Koontz, Toronto, McGraw-Hill, 1971, 239p.
- 3. C.A.U.T. handbook. Ottawa, Canadian Association of University Teachers, 1971.
- 4. Children in Canada: residential care, by Quentin Rae-Grant and Patricia J. Moffat. Toronto, Canadian Mental Health Associa-1ion, 1971. 127p.
- 5. The Chinese art of healing, by Stephan Palos, Toronto, Bantam Books, 1972, 237p. 6. Clinical obstetrics and gynecology, v.14, 110.4. New York, Harper & Row, Dec. 1971. 1344p.
- 7. The composition and function of body fluids, by Shirley R. Burke, St. Louis, Mosby, 1972, 100p.
- 8. Counseling, evaluation and student development in nursing, education, by Lawrence Litwack et al. Toronto, Saunders, 1972.
- 9. A degree and what else? correlates and consequences of a college education, by Stephen B. Withey. New York, McGraw-Hill, 1971. 147p.
- 10. Ear, nose and throat; a short textbook. by P.M. Stell et al. London, English Universities Press, 1971, 155p.
- 11, Early care of the injured patient, by the American College of Surgeons, Committee on Trauma, Toronto, Saunders, 1972.
- 12. Emotional care of hospitalized children; an environmental approach, by Madeline Petrillo and Sirgay Sanger, Toronto, Lippincott, 1972, 259p.

HOLLISTER

write for free samples, prices and information

HOLLISTER INCORPORATED . 211 EAST CHICAGO AVENUE, CHICAGO, ILLINOIS 60611

13. Family therapy: a triadic-based approach, by Gerald H. Zuk. New York, Behavioral Publications, 1971. 239p.

14. Fundamentals of anesthesia care, by Betty J. Smith, St. Louis, Mosby, 1972. 120p. 15. Good health; personal and community, Benjamin F. Miller and John J. Burt. 3ed. Toronto, Saunders, 1972, 494p.

16. In sickness and in health; reflections on the medical profession, by Earle P. Scarlett, Edited by Charles G. Roland, Toronto, McClelland and Stewart, 1972.

17. Learning experience guides for nursing students, vol. 1. New York, Wiley, 1970. 2 cassettes and audio tape guide.

18. Man as the measure: the crossroads, by Daniel Adelson. New York, Behavioral Publications, 1972. 146p. (Community psychology series no.1)

19. Managing associations for the 1980's, by Robert M. Fulmer, Washington Foundation of the American Society of Association Executives, 1972, 103p.

20. The Merck manual of diagnosis and therapy, by Merck and Company, Inc. 12ed. Rahway, N.J., Merck Sharp & Dohme Research Laboratories, 1972. 1964p.R

21. Microbiology in modern nursing, by H.I. Winner. rev. London, English Universities Press, 1970, 184p.

22. New standard references for secretaries and administrative assistants, by J. Harold Janis and Margaret H. Thompson, New York, Macmillan, 1972. 801p.

23. The new world secretarial handbook. Edited by A. E. Klein. rev. New York, World Publishing, 1972. 659p.

24. The newborn and the nurse, by Mary Lou Moore, Toronto, Saunders, 1972, 290p.

25. Obstetrics and gynaecology for nurses, by Gordon W. Garland et al. 3ed. London, English Universities Press, 1971. 205p.

26. Ophthalmology, by Ian M. Duguid and Anne A. Berry. London, English Universities Press, 1971. 150p.

27. Organization research on health institutions. Edited by Basil S. Georgopoulos. Ann Arbor, Mich., Institute for Social Research, University of Michigan, 1972. 418p.

28. Outline of fractures including joint injuries, by John Crawford Adams, 6ed. Edinburgh, Churchill Livingstone, 1972. 312p.

29. Personal health behavior in today's society, by John J. Burt and Benjamin F. Miller. Toronto, Saunders, 1972. 417p. 30. The pills in your life, by Michael Halberstam. New York, Grosset & Dunlap, 1972. 200p.

31. Poverty and the child; a Canadian study, by Thomas J. Ryan. Toronto, McGraw-Hill, 1972. 254p.

32. Practical approaches to effective functioning of the department of nursing service; a guide for administrators of nursing service. Chicago, American Hospital Association, 1972, 85p.

33. Practical nurse nutrition education, by Alberta Dent Shackelton. 3ed. Toronto, Saunders, 1972, 306p.

34. Le prix de la santé par Jean-Luc Migué

et Gérard Bélanger, Montréal, Hurtubise HMH, 1972, 238p.

35. Psychiatric nursing as a human experience, by Lisa Robinson. Toronto, Saunders, 1972. 352p.

36. Quick medical terminology, by Genevieve Love Smith and Phyllis E. Davis. New York, Wiley, 1972, 248p.

37. Rehabilitative aspects of acute and chronic nursing care, by Ruth Perin Stryker. Toronto, Saunders, 1972. 236p.

38. The senseless sacrifice: a black paper on medicine, by Heward Grafftey, Toronto. McClelland and Stewart, 1972, 166p.

39. Smiling through tears. Vol. 2: Experience

as a nurse, by Vera Ernst McNichol. 408p.

40. Some objective approaches to evaluation; case presentations. New York, National League for Nursing, 1972. 57p. (League exchange no. 98)

41. Study of auxiliary nursing personnel and their position in relation to national nurses associations. Summary report by Helen Foerst. Geneva, International Council of Nurses, 1972, 69p.

42. Styles of address; a manual of usage in writing and speech, by Howard Measures. 3ed. Toronto, Macmillan, 1969. 161p. R

43. A systematic approach to the nursing care plan, by Marlene Glover Mayers. New



- When immediate bedside aspiration is needed this Model 789 portable unit is indispensable at the nurses' station.
- Light weight and compact, it occupies less than 1 square foot of shelf space and provides upwards of 22" vacuum in seconds.
- Equipped with precision regulator valve and gauge calibrated in inches and centimeters for positive control of suction.
- Patented safety overflow valve automatically shuts off system if moisture occurs beyond suction bottle, preventing damage to pump.

Larger, heavy duty aspirators with up to 25" vacuum, both portable and stand mounted models, are also available.

828 Eest Ferry Street



See your surgical supply dealer or write:



SURGICAL MANUFACTURING CORPORATION

Buffalo, New York 14211

# accession list

York; Appleton-Century-Crofts, 1972. 304p. 44. Technical nursing; dimensions and dynamics, by Sandra Rasmussen. Philadelphia, Davis, 1972, 169p.

45. Therapeutic recreation: its theory, philosophy and practice, by Virginia Frye and Martha Peters. Harrisburg, Pa., Stackpole Books, 1972. 223p.

46. Toward an industrial gerontology; an introduction to a new field of applied research and service. Washington Seminar on Industrial Gerontology, 1968, edited by Harold L. Sheppard. Cambridge, Mass., Schenkman, 1970, 165p.

47. 20,000 medical words, by Robert W. Prichard and Robert C. Robinson. Toronto, McGraw-Hill, 1972. 269p.

48. Using the library: the card catalog, by Charles I. Bradshaw with Marvin E. Wiggins and Blaine Hall, Provo, Utah, Brigham Young University Press, 1971. 104p.

49. Working together. A study of coordination and cooperation between general practitioner, public health and hospital services. London, King Edward's Hospital Fund for London, 1968, 76p.

50. Your future in hospital work, by Weir Richard Kirk, New York, Arco, 1971, 124p.

PAMPHIETS

51. Analysis of "Medical Record." Montreal. Association of Nurses of the Province of Quebec, 1972. 6p.

52. An annotated bibliography of selected Canadian reports and studies of the school health programme. Compiled by Glynis G. Saylor. Ottawa, National Conference on School Health, 1971, 41p.

53. The board member in the community agency. Proceedings of the Board Members Forum. New York. National League for Nursing, 1972. 32p.

54. Briefs submitted to the Special parliamentary committee of the National Assembly of Quebec for professional corporations on bills 250, 273. Montreal, Association of Nurses of the Province of Quebec, 1972. 30p. 55. CEGEP nursing education after five years. Montreal, Association of Nurses of the Province of Quebec, 1972, 25p.

56. Communication problems after a stroke, by Lillian Kay Cohen. Minneapolis, Minn., Kenny Rehabilitation Institute, 1971, 40p.

57. Copyright law and library photocopying practices in Canada and the United States; background materials. Compiled by Peter S. Grant and prepared for the Upstate York Regional Group, Medical Library Association, Toronto Meeting, October 20, 1972. Toronto, 1972, 45p.

58. Differentiation between technical and professional nursing; an annotated bibliography, by Shirley Chater, Holly Skodol

Wilson and Verle H. Waters. New York. National League for Nursing, 1972, 31p. 59. Etude sur l'acte infirmier dans les différents centres de santé de la province de Québec. Montreal, Association des Infirmières et Infirmiers de la Province de Québec, 1972, 42p.

60. Facing facts. New York, National League for Nursing, Dept. of Diploma Programs, 1972. 35p.

61. Florence Nightingale at Harley Street; her reports to the governors of her nursing home, 1853-54. London, Dent, 1970. 36p.

62. Guidelines for developing standards for nursing care. Ottawa, Canadian Nurses' Association, 1972, 38p.

63. Licensed practical nurses in nursing services. New York, National League for Nursing, 1972. 36p.

64. Notice bibliographique de textes choisis parmi les études et rapports canadiens touchant le programme d'hygiène en milieu scolaire. Comp. par Glynis G. Saylor. Ottawa, Conférence nationale sur l'hygiène en milieu scolaire, 1972, 41 p.

65. Nurse — nursing assistant; roles, functions. Montreal, Association of Nurses of the Province of Quebec, 1972. pam.

66. Nurse education for family planning for the Canadian National Conference on Family Planning, Ottawa, Feb. 28-Mar. 2, 1972. Ottawa, Canadian Nurses' Association. 1972. 9p.

67. Partial results of the study on the nurs-

# Request Form for "Accession List"

# CANADIAN NURSES' ASSOCIATION LIBRARY

Send this coupon or facsimile to:

IIRDADIAN	Canadian	Murces'	Association	50 T	he Driveway	Offawa	Ontario	K2D 1	F2

		issue of The
Canadian Nu	irse, or add my name to the w	raiting list to receive them when available:
No.	Author	Short title (for identification)
***************		
*****************		
	r loans will be filled in order and restricted material must	of receipt. be used in the CNA library.
Borrower		Registration No.
Address		
Date of requ	uest	

ing act in health centres of the province of Quebec, Montreal, Association of Nurses of the Province of Quebec, 1972, 26p.

68. Observations on the supply and demand of nurses in Quebec, by Barbara G. Kuhn. Montreal, Association of Nurses of the Province of Quebec, 1972, 17p.

69. Projet d'orientation: draft. Montréal, Association des Infirmières et Infirmiers de la Province de Québec, 1972. 9p.

70. Projet pilote d'actualisation professionnelle pour infirmières présenté au Ministère des Affaires sociales. Montreal, Association des Infirmières et des Infirmiers de la Province de Québec, déc. 1971.

71. A submission to the Commission on Educational Planning. Edmonton, Alberta Association of Registered Nurses, 1972. 24p.

# **GOVERNMENT DOCUMENTS**

Alberta

72. Commission on Educational Planning. *A future of choices; a choice of futures.* Edmonton, Queen's Printer, 1972. 325p.

Canada

73. Dept. of National Health and Welfare. Comprehensive training in psychiatry, by Paul M. Cameron and Stanley E. Greben. Ottawa, 1972. 10p. (Canada's mental health. Supplement no. 72)

74.—. Foster homes: the new back wards? by H.B.M. Murphy et al. Ottawa, 1972. 17p. (Canada's mental health. Supplement no. 71)

75.—. Child and Maternal Health Division. *Up the years from one to six.* rev. ed. Ottawa, Information Canada, 1971. 200p.

76. Economic Council of Canada. Canadian higher education in the seventies. Edited by Sylvia Ostry. Ottawa. Information Canada. 1972. 310p.

77. Medical Research Council. Grants and wards guide (extramural program). Ottawa, Information Canada, 1972. 124p.

78. Ministère de la Santé Nationale et du Bien-Etre social. Les techniques de sensibilisation au Canada: perspective et comnentaires, par Hedley G. Dimock. Ottawa, 1971. 18p. (Hygiène mentale au Canada. Supplément no. 69)

79.—. Publications "Bon Marché" sur l'hygiène mentale 1971-1972.— Ottawa, 1971. 13p. (Hygiène mentale au Canada, Supplénent no. 70)

30. Statistics Canada, Trends and factors of ertility in Canada, by Jacques Henripin. Dttawa, 1972. 421p. (Census of Canada 1961. Monograph)

Great Britain

31. Department of Employment and Proluctivity. Cost-benefit aspects of manpower etraining; a study, by James J. Hughes. London, HMSO, 1970, 42p.

32. Joint Board of Clinical Studies. Report, st. London, 1972. Iv. (unpaged)

33. Secretary of State for Social Services, Committee on Nursing. *Report*. London, HMSO, 1972. 327p.

Inited States

14. Dept. of Health, Education and Welfare, lational Institutes of Health. Medicine

and public health in the People's Republic of China. Edited by Joseph R. Quinn. Bethesda, Md., 1972. 305p. (U.S. DHEW Publication no. (NIH) 72-67)

85. National Institutes of Health. Clinical Center. *Professional progression in the nursing department.* Bethesda, Md., 1972. 18p. (U.S. DHEW Publication no. (N1H) 72-294)

# STUDIES DEPOSITED IN CNA

REPOSITORY COLLECTION

86. The development of clinical nursing situations on videotape for use via closed-circuit television in the teaching of nursing. Final report, by Moyra Allen. Montreal, School of Nursing, McGill University, 1972. 56p, R

87. An educational program for nurse practitioners; report on demonstration project. Principal investigators: Dorothy J. Kergin and W.O. Spitzer. Hamilton, Ont., Division of Health Sciences. McMaster University, 1972. 22p. R

88. The effects of error modeling on the learning of a complex procedure in nursing, by Nora Inez Parker. Toronto, 1972. 136p. (Thesis - Toronto) R

89. Etude d'un enseignement par texte programmé relativement à la continuité de l'allaitement maternel à domicile, par Marie-Elizabeth Taggart, Montréal, 1971. 114p. (Thèse (M. Nurs.) - Montréal) R.

90. Evaluation des effets d'un programme d'éducation appliqué chez des malades mentaux diabétiques, par Thérèse Hardy. Montréal, 1970. 163p. (Thèse (M.Nurs.) - Montréal) R

91. An examination of the role of the staff nurse in a general hospital, by Brendan J. Minihan, Albany, N.Y., 1969, 126p. (Thesis (M.H.A.) - Ottawa) R

92. The expanded role of the nurse; a working paper. Part 1 and Part 2, by Rachel Lamothe. Ottawa, Canadian Nurses' Association, 1972. 37p. R

93. Population, family planning and related health care: a working paper, by Nancy Garrett. Ottawa, Canadian Nurses' Association. 1972, 62p. R

94. A study of change in a hospital: the implementation of a unit management system, by Sheila M. Ryan. Edmonton, 1972, 100p. (Thesis (M.H.S.A.) - Alberta) R

95. A study to develop instruments to evaluate the effectiveness of a post-diploma program in nursing, by Roberta Edith Rivett. London, Ont., 1972, 143p. (Thesis (M.Sc.N) - Western)R

96. A study to identify problems experienced by patients having therapeutic abortions on the one-day surgical slate, by Mary L. Richmond MacBean, project director and Elizabeth Ashton, chief investigator. Vancouver, B.C., Vancouver General Hospital, 1972. 37p. R

97. A study to investigate the effect of compulsory arbitration legislation on the collective bargaining process in selected Ontario hospitals, by Paul A. Miller. Ottawa, 1969. 169p. (Thesis (M.H.A.) - Ottawa) R



# ENJOY NURSING AT VICTORIA HOSPITAL LONDON ONTARIO

Apply To:-

Personnel Co-Ordinator, Personnel Office, Victoria Hospital, London, Ontario.

Name:	
Reg.N.	R.N.A.

# classified advertisements

### ALBERTA

FACULTY — ASSOCIATE OR FULL PROFESSOR TO TEACH AND DIRECT RESEARCH IN NEW TWO-YEAR CLINICAL NURSING MASTER'S PROGRAM IN NURSING IN ACUTE ILLNESS. DOCTORAL DEGREE, ADVANCED CLINICAL PREPARATION AND EXPERIENCE IN THESIS ADVISEMENT RE-OUIRED. APPLY TO: RUTH E. McCLURE, M.P.H. DIRECTOR, SCHOOL OF NURSING, THE UNIVERSITY OF ALBERTA, EDMONTON, ALBERTA, T6G 2G3. POSITION AVAILABLE IMMEDIATELY.

REGISTERED NURSES required for a 30-bed Genral Hospital, salary and Personnet Policies as per AARN. Location of hospital, 80 miles east of Lacombe, Highway No. 12. For more information write or phone 882-3434, Director of Nursing, Our Lady of the Rosary Hospital, Castor, Alberta.

PUBLIC HEALTH COMMUNITY HEALTH NURSE. The Mount View Health Unit and University of Calgary, through the Ambulatory Care Centre of the Faculty of Medicine invite applications for the post of Public Health Community Nurse, with a public health background for the Cochrane area near the city of Calgary. This will be a new appointment and the successful candidate will carry the general public health program together with Domicillary Nursing Care programs. Salary schedule will be that of the Mount View Health Unit and depend upon qualifications and experience. For further details and application forms please apply to: Dr. J. O'Gorman, Medical Officer of Health, Mount View Health Unit, 2202-Edmonton Trail N.E., Calgary, Alberta.

# ADVERTISING RATES

FOR ALL
CLASSIFIED ADVERTISING

\$15.00 for 6 lines or less \$2.50 for each additional line

Rotes for display advertisements on request

Closing date for copy and concellation is 6 weeks prior to 1st day of publication month.

The Conodian Nurses' Association does not review the personnel policies of the hospitols and agencies advertising in the Journal. For authentic information, prospective applicants should apply to the Registered Nurses' Association of the Province in which they are interested in working.

Address correspondence to:

Canadian Nurse



50 THE DRIVEWAY OTTAWA, ONTARIO K2P 1E2

### ALBERTA

REGISTERED NURSES required immediately for 72-bed accredited, active treatment hospital. (Vacancies on all units) AARN — AHA contract in force. Apply: Director of Nursing, Providence Hospital, High Prairie, T0G 1E0, Alberta.

## BRITISH COLUMBIA

EDUCATION AND RECRUITMENT OFFICER required for acute care Hospital currently expanding to 385-beds. To be responsible for the co-ordination and development of all educational programmes and to supervise the recruitment and orientation programmes within the Hospital, Applicants should have experience and/or training in educational methods and personnel development, Hospital experience would be an asset. Salary range: \$700 — \$800 per month depending upon related experience, Apply to: Assistant Administrator, Prince George Regional Hospital, 2000 15th Avenue, Prince George, British Columbia, Canada.

AN EXCITING AND CHALLENGING HEAD NURSE POSITION IS NOW AVAILABLE IN VICTORIA GENERAL HOSPITAL'S OPERATING ROOM. WE REQUIRE A PERSON WITH PREVIOUS EXPERIENCE AND PREPARATION, AND THE PERSONALITY TO MEET THE DEMANDS OF THIS PRESSURE AREA WHILE ENJOYING THE ADVANTAGES OF LIVING IN THE BEAUTIFUL GARDEN CITY OF VICTORIA. SALARY IN ACCORDANCE WITH RNABC CONTRACT. PLEASE APPLY TO: MRS. A.G. SIMPSON, R.N., ACTING DIRECTOR OF NURSING SERVICE, VICTORIA GENERAL HOSPITAL, VICTORIA, BRITISH COLUMBIA.

OPERATING ROOM NURSE wanted for active modern acute hospital. Four Certified Surgeons on attending staft. Experience or training desirable. Must be eligible for B.C. Registration. Nurses residence available. Salary \$687 per month starting. Apply to: Director of Nursing, Mills Memorial Hospital, 2711 Telrault St., Terrace, British Columbia.

OPERATING ROOM NURSES for modern 450-bed hospital with School of Nursing, RNABC policies in effect. Credit for past experience and postgraduate training. British Columbia registration is required. For particulars write to: The Associate Director of Nursing, Victoria General Hospital, Victoria, British Columbia.

EXPERIENCED NURSES required in 409-bed acute Hospital with School of Nursing. Vacancies in medical, surgical, obstetric, operating room, pediatric and Intensive Care areas. Basic salary \$672.—\$842. B.C. Registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

PROVINCE OF BRITISH COLUMBIA requires REGISTERED NURSES for the Mental Health Branch in Vancouver and Interior areas of the Province. For application forms and further information, apply IMMEDIATELY to the: CIVIL SERVICE COMMISSION, Valleyview Lodge, Essondale. British Columbia. Competition No. 72: 1211.

EXPERIENCED GENERAL DUTY NURSES — required for small up-coast hospital. Salaries start at \$672.00. Residence accommodation at \$25.00 per month. 20 days annual vacation. Transportation paid from Vancouver, B.C. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia.

GENERAL DUTY NURSE wanted for 87-bed modern hospital. Nurses Residence. Salary \$646,00 par month for BC Registered. Apply: Director of Nursing, Mills Memorial Hospital, Terrace, British Columbia.

## BRITISH COLUMBIA

GENERAL DUTY NURSES for modern 41-bed hospital, located on the Alaska Highway. Salary and personnel policies in accordance with RNABC. Accommodation available in residence. Apply: Director of Nursing, Fort Nelson General Hospital, Fort Nelson, British Columbia.

GENERAL DUTY NURSES, for modern 35-bed hospital located in southern B.C.'s Boundary Araa with excallent recreation facilities. Salary and personnel policias in accordance with RNABC. Comfortable Nurses's homa. Apply: Director of Nursing, Boundary Hospital, Grand Forks, British Columbia.

WANTED: GENERAL DUTY NURSES for modern 70-bed hospital, (48 acute beds — 22 Extended Cara) located on the Sunshina Cdast, 2 hrs. from Vancouver. Salaries and Personnal Policies in accordance with RNABC Agraement. Accommodation availabla (female nursas) in residenca. Apply: Tha Director of Nursing, St. Mary's Hospital, P.O. Box 678, Sechelt, British Columbia.

GENERAL DUTY NURSES for modern 450-bed hospital with School of Nursing, RNABC policies in effect. Credit for past experience and postgraduate training, B.C. registration required. For particulars write to: Acting Director of Nursing, Victoria General Hospital, Victoria, British Columbia.

### MANITOBA

REGISTERED NURSES are required for the following positions in a 68-bed General Hospital: Evening Supervisor, Night Supervisor, Head Nursa in Combinded Medical and Surgical Ward and Pediatric Ward, and General Duty Nurses. Salaries in accordance with M.H.S.C. approved rates. For further information apply: Administrator, Ste Rose General Hospital, Ste Rose, Manitoba.

Required a DIRECTOR OF NURSING to begin March 15/73 and 2 R.N.'s to begin May 15/73 for a 21-bed, fully equipped modern hospital; living accommodations available; salary as per schedule. Apply to the: Administrator, Gilbert Plains District Hospital, Gilbert Plains, Manitoba ROL 0XO.

# NOVA SCOTIA

REGISTERED NURSES, PSYCHIATRIC NURSES and CERTIFIED NURSING ASSISTANTS. General staff positions available in this modern, 270-bed psychiatric hospital, located in the Annapolis Valley. Orientation and Inservice providad. Excellent personnel policies and salary to commensurate with qualifications and experience. For further information direct inquiries to: The Director of Nursing, Kings County Hospital, Waterville, Nova Scotia.

# ONTARIO

OPERATING ROOM SUPERVISOR required for fully accredited, 75-bed General Hospital. You will be in the Vacationland of the North, midway betwaen Thunder Bay, Ontario and Winnipeg, Manitoba. Basic wage is \$668.00 with consideration for experiance. Write or phona the: Director of Nursing, Dryden District General Hospital, Dryden, Optario

# The Canacian Nurse

April 1973

OUT OF LIBRARY

11 AVR 1973

UNIVERSITY OF OTTAWA NURSING LIBRARY OTTAWA. ONT. KIN 6N5 12-73-10-71-CN-INV. 3087



Commemorative stamp issued to honor Jeanne Mance





# Gareer Apparel



Do you realize.

You meet more people while weari your uniform than any other clothing you own...

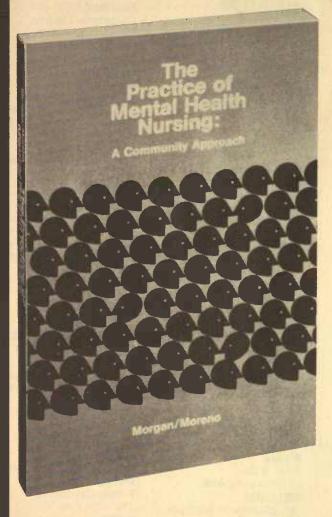
Shouldn't it be the nicest...





CAREER APPAREL

# FOR MORE PERCEPTIVE NURSE-PATIENT INTERACTION...



#### NEW!

#### THE PRACTICE OF MENTAL **HEALTH NURSING**

#### A Community Approach

The first of its kind for undergraduate students of professional nursing, this text, by a nurse and a psychiatrist active in community mental health service, emphasizes reality-oriented practice and concepts basic to patient care. The book reflects the dynamic quality of psychiatric care in a community setting and desirable colleague relationships required for successful treatment of the emotionally disturbed. Innovative, philosophical and patient-centered, it is unique for its clear, direct presentation of human behavior and treatment modalities. The absence of traditional and often mysterious psychiatric jargon will appeal to students as well as experienced nurse practitioners.

By Arthur J. Morgan, Jr., M.D.; and Judith W. Moreno, R.N., M.S.N. April 1973 - 225 pages

#### SERVING THE HEALTH PROFESSIONS IN CANADA SINCE 1897



J. B. Lippincott Company of Canada Ltd. 75 Horner Ave.

Toronto, Ontario M8Z 4X7

**ALBERTA** CALGARY The Bay Simpsons-Sears

Vogue Dress Shop **EDMONTON** 

The Bay Eaton's Johnstone Walker Rose Uniform Shop Simpsons-Sears

LETHBRIDGE Eaton's Fays Apparel LLOYDMINSTER

Walkrite Ltd.

Ellen Rick Ltd. Vivian Style Shop MEDICINE HAT

Petite Style Shop RED DEER

The Bay

**BRITISH COLUMBIA** 

BURNABY Simpsons-Sears FORT ST. JOHN

Model Dress Shop GIRSON

Goddard Fashions KAMLOOPS

The Bay KELOWNA Sha-Dori Specialty

LOUGHEED The Bay PENTICTON The Bay

PRINCE GEORGE

The Bay REVELSTOKE

Revelstoke Co-op Associates RICHMOND The Bay

**SMITHERS** Village Fashions

SURREY The Bay TERRACE

Terrace Co-op Associates TRAIL

VANCOUVER The Bay T. Eaton Co. Ltd. Jermaine's Ltd. Miss K. Raynier

The Bay

The Bay

Rose Uniforms VERNON

VICTORIA The Bay Eaton's Lady Mae Shoppe Simpsons-Sears

**MANITOBA** 

THE PAS Shirl's Boutique PORTAGE LA PRAIRIE Marr's Fashion

WINNIPEG The Bay T. Eaton Co. Ltd. Rose Lee Fashion Uniforms 265 Kennedy 837 Sherbrook St.

**NEW BRUNSWICK FREDERICTON** Levine's Ltd. MONCTON Eaton's George Battah Ltd. Simpsons-Sears SAINT JOHN Calp's Limited Manchester, Robertson, Allison Ltd. Simpsons-Sears

NEWFOUNDLAND CORNER BROOK Sutton's Style Shop ST. JOHN'S The London, New York & Paris Association of Fashions Ltd.

**NOVA SCOTIA ANTIGONISH** Wilkie Cunningham DARTMOUTH Jacobsons of Dartmouth GLACE BAY Ein's Ltd.

HALIFAX Eaton's The Robert Simpson Co. Ltd. Uniform Shoppe SYDNEY

Jacobson's Ladies Wear Uniform Shop 330 Charlotte St.

**ONTARIO** 

BELLEVILLE Jackson Metivier Uniform Shop 265 Front St. McIntosh Bros. 257 Front St. BRAMPTON

Purple Pelican Shoppers World Shopping Centre BRANTFORD Uniform Shoppe

37 King St. CHATHAM **Artistic Ladies Wear** Uniform Shoppe 63 Fouth St.

117 King St. West HAMILTON T. Eaton Co. Ltd. Florence Nightingale Shop 156 James St. S. Lockharts Ladies Wear 603 Concession St. The G. W. Robinson Co. Ltd. 18-24 James St. S. Simpsons-Sears

KINGSTON Simpsons-Sears Uniform Shop 20 Montreal St. **KITCHENER** Uniform Salon

332 King St. E. Simpsons-Sears LONDON The Clothes Tree 1201 Oxford St. Eaton's **Uniform Centre** Wellington Square Uniforms Unlimited 723 Richmond St. **MISSISSAUGA** White Dove 58 Dundas St.

**OSHAWA** Simpsons-Sears **OTTAWA** A. J. Freiman

C. Caplan Ltd. Simpsons-Sears Uniform World 252 Bank St. OWEN SOUND

Sylphene's of Owen Sound 854 - 2nd Ave. E.

**PETERBOROUGH Uniform Shop** 445 St. George St. Simpsons-Sears RENFREW

Uniform World 170 Renfrew Ave. ST. CATHARINES

Magder's Uniform Shop 40 Queenston St. Simpsons-Sears ST. THOMAS

Gerrard's Shop 639 Talbot SARNIA

**Uniform Shop** 225 N. Front St. Simpsons-Sears SUDBURY

**Uniform Centre** 84 Elm St. W. Eaton's THUNDER BAY

Eaton's TORONTO T. Eaton Co. Ltd. Robert Simpson Co. **Uniform Specialty** 30 Bloor St. W. Uniform World 641 Bay St.

WAWA West & Co. 52 Broadway Ave. WELLAND Select Uniform Shoppe

179 King St. WINDSOR Adelman's Dept. Store 60 Pitt St. E. Simpsons-Sears **Uniform Centre** 324 Pelissier St.

WOODSTOCK Gerrard's Shop 399 Dundas St.

PRINCE EDWARD ISLAN CHARLOTTETOWN Eaton's Fashion Shoppe 141 George St. SUMMERSIDE

Smallman's Ltd.

QUÉBEC CHICOUTIMI Spécialités Suzette Inc. 418 est, rue Racine 1 Place Saguenay

JONQUIÈRE Corseterie Louise 444 St-Dominique LAUZON

J. E. Paré & Fils MONTREAL Eaton's **Uniform Boutique** 5729 Côte des Neiges

575 Maisonneuve Blvd. W. 800 St. Catherine St. E. QUEBEC CITY Les magasins MIIe Uniforme 1121 rue St-Jean

Lyne Enrg. 2461 boul. Ste-Anne Place de l'Uniforme 2750 Chemin Ste-Foy Maurice Pollack Ltd. 750 boul. Charest Le Syndicat de Québec 405 rue St-Joseph Simpsons-Sears

STE-FOY Jacqueline Thibeault 2700 Place Laurier ST-GEORGES DE BEAUCE Confection Simone ST-HYACINTHE Mme Rita Bibeau Massé 1665 rue des Cascades

TROIS-RIVIÈRES Maurice Pollack Ltée

SASKATCHEWAN PRINCE ALBERT C.B. Department Store PRINCE RUPERT Fraser Co. Stores 210 - 3rd Ave. W.

REGINA Eaton's SASKATOON Fashion Uniforms 150 - 2nd Ave. N. Eaton's Simpsons-Sears



PROMINENT DEALERS listed alphabetically by geographic location

CARRY A FINE SELECTION OF \| IN'S FOR SPRING

## The Canadian Nurse



A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 69, Number 4

**April 1973** 

- Freedom: An Outmoded Tradition ...... J. Gilchrist
- Changing Nursing Practice Through Education ...... D.J. Kergin, M.A. Yoshida, W.O. Spitzer, J.E. Davis, E.M. Buzzell
- A New Method of Tubal Ligation ...... B. McBride
- Laparoscopy ...... P.J. Beardall
- Auscultation of the Chest — A Clinical Nursing Skill ......G. Slessor

The views expressed in the editorial and various articles are those of the authors and do not necessarily represent the policies or views of the Canadian Nurses' Association.

- 4 Letters
- News
- 22 New Products
- Dates
- 46 In a Capsule
- Names
- 50 Research Abstracts
- Books
- 54 Accession List
- 72 Official Directory

Executive Director: Helen K. Mussallem • Editor: Virginia A. Lindabury • Assistant Editors: Liv-Ellen Lockeberg, Dorothy S. Starr • Editorial Assistant: Carol A. Dwor-kin • Production Assistant: Elizabeth A. Stanton • Circulation Manager: Beryl Darling • Advertising Manager: Georgina Clarke • Subscription Rates: Canada: one year, \$6.00; two years, \$11.00. Foreign: one year, \$6.50; two years, \$12.00. Single copies: .75 cents each. Make cheques or money orders payable to the Canadian Nurses' Association.

• Change of Address: Six weeks' notice: the old address as well as the new are necessary, together with registration number in a pro-vincial nurses' association, where applicable. Not responsible for journals lost in mail due to errors in address.

Manuscript Information: "The Canadian Nurse" welcomes unsolicited articles. All manuscripts should be typed, double-spaced, on one side of unruled paper leaving wide margins. Manuscripts are accepted for review for exclusive publication. The editor reserves the right to make the usual editorial changes. Photographs (glossy prints) and graphs and diagrams (drawn in india ink on white paper) are welcomed with such articles. The editor is not committed to publish all articles sent. nor to indicate definite dates of publication.

Postage paid in cash at third class rate MONTREAL, P.O. Permit No. 10,001. 50 The Driveway, Ottawa, Ontario. K2P 1E2

Canadian Nurses' Association 1973.

The story of Jeanne Mance, North America's first secular nurse and the founder of l'Hôtel-Dieu de Montréal, is familiar to all RNs. We know she left France in 1641 to join a small expedition that set sail to establish the colony of Ville-Marie. We know, too, she was well aware of the dangers and the difficult life she would encounter there. Yet. like others who have left their mark on history, she felt called on to undertake this mission and to devote her life to humanity.

Even so, she apparently "wrestled with the spirit that had taken possession of her." In his book Jeanne Mance — Her Life, the late J.K.

Foran wrote:

"... she reflected upon the magnitude of the undertaking and upon her feeble state of health, the risks, the lack of funds, her isolation.... Discouraged on all sides, she tried to persuade herself that it was all an illusion; but despite her every effort, the vision of faraway Canada still haunted her dreams by night and her thoughts by day.

Perhaps the best summary of Jeanne Mance's achievements is found in a review of Foran's book. Published in The Montreal Daily Star, Dec. 5, 1931, the review states

"She was an angel of mercy in a rough age, a heroine who, by her own courage, endurance, fortitude, and persistence, succeeded in her great desire, which was to establish a hospital in Ville-Marie. It was she who interested the generous Mme de Bullion in her scheme, and secured from that lady financial help that gave her hope and set her feet steadfast toward La Nouvelle France. Conditions when she arrived here did not daunt her; indeed, nothing seems to have daunted her. She did her work; she won her way; she established her hospital; she served the sick with selfsacrificing devotion; and she died beloved by all those who knew her, blessed by those to whom she had brought relief. . . . "

This year marks the three hundredth anniversary of the death of Jeanne Mance. The commemorative stamp issued to honor her serves to remind us of the extraordinary devotion and self-sacrifice of this saintly woman. The legacy she has bequeathed will forever be treasured by Canadian nurses. — V.A.L.

### letters

Letters to the editor are welcome.

Only signed letters, which include the writer's complete address, will be considered for publication.

Name will be withheld at the writer's request.

New role challenging

I would like to comment on the article "I Hate Nurses!" by Dr. Rudnick (November 1972) and the replies to it by mentioning my experiences at the hospital where I work.

Like many other nurses, 1 felt 1 had no opportunity to fulfill the goals I knew were possible. I began to think that perhaps nursing was not the profession for me, because I needed more challenge and stimulation intellectually and the responsibility I felt I could assume.

After discussing this subject with some residents and staff doctors, 1 realized these particular doctors understood my feelings and were waiting for nurses to show them they were ready to expand their role. As a result, a resident proposed the "primary therapist." This meant a nurse expanded her duties to include taking histories, assessing mental status, doing physiotherapy and progress notes under supervision.

We received extra lectures on psychotherapy, medications, and so on. Of course, not all the nurses were ready to take on this new role. I have found this role exciting, challenging, and more rewarding. I could not return

to the old way.

It is much easier to complain than to take constructive action. Any nurse who really wants to expand her role will find the opportunity. — R.N., Ontario.

#### Health care clinic

I would like to describe the health care clinic I direct at the Winnipeg General Hospital outpatient department. The objective of this clinic, which was set up in March 1972, is to provide safe health surveillance or followup and counseling to meet the individual's needs.

During my clinic one afternoon a week, I see up to four patients. At present, my case load is 24. Patients are referred from the general or specialty clinics. Well-suited for this type of care are individuals with chronic disorders who require continuing care and monitoring, but whose disease is fairly stable.

Patients are referred by doctors who are interested in this augmented program. The patients are told about the clinic, that a nurse will see them, and

that a doctor will be called if necessary. A doctor is available if I require help; repeat prescriptions or orders for tests are arranged through him.

We hope that, with continual monitoring, complications of a disease will not develop and hospital admissions and clinic visits will be reduced. Most patients attending the clinic are 50 years and older. The most common mild hypertension, diagnoses are congestive heart failure, anxiety neuro-

ses, and obesity.

In my first interview with the patient, I try to get information about his living conditions, what he knows about his disease, and how diet, medication, and daily activities affect his disease. I want to know if he recognizes symptoms of remission, which should be reported. Patients have my name and hospital telephone number and are always free to call me.

Ms. Y. is a good example of how this clinic helps patients. For many years, Ms. Y. has come to the outpatient department with numerous problems. She has received orthopedic care, is on medication from a psychiatrist, and has attended three different clinics.

When Ms. Y. comes to see me once a month, she has time to tell me about her pains, her daughter, and all her activities. We talk about her diet and what causes her chest pain. I make suggestions that I know she tries to carry out, as she wants to please me. On each visit Ms. Y. has fewer complaints about her health and needs less reassurance. Her visits to other clinics have decreased, except for psychiatry.

Most patients I see appear happy with the clinic. In the future I see other nurses in the department having similar clinics. We hope the patient will contact the nurse and be seen by the physicians only when their specific skills are required. — Isabel Aikman, R.N., supervisor of outpatient department, Winnipeg General Hospital,

Winnipeg, Manitoba.

#### **Letters Welcome**

Letters to the editor are welcome. Because of space limitation, writers are asked to restrict their letters to a maximum of 350 words.

Nursing in St. Lucia

I was interested to see the photograph and caption in the February issue (News, page 8) of the nurses at the Victoria Hospital in Castries, St. Lucia, West Indies.

My daughter and a classmate of hers, both graduates of the Saint John General Hospital in Saint John, New Brunswick, and another Canadian nurse from Edmonton, Alberta, are working as volunteer RNs at St. Jude Hospital in Vieux Fort, St. Lucia. They are finding their work an interesting and re-warding experience. — "Proud mom" (name withheld on request), New Brunswick.

VGH plans anniversary

The Vancouver General Hospital Alumnae Association is planning a gala celebration of the school of nursing's 75th anniversary in 1974. Anniversary plans from May 2 to 4 that year include a banquet at the Regency Hyatt Hotel.

Alumnae officers are anxious to contact as many graduates of the school as possible. Any graduate who has not received a 1972 alumnae newsletter should send her name (including maiden name), year of graduation, and address.

This information should be mailed to the Executive Secretary, VGH Alumnae Association, 2851 Heather Street, Vancouver 9, B.C.

Extended day in critical care unit

Six months have passed since we began a twelve-hour work day in our eightbed intensive coronary care unit. We decided to extend the work day mainly because of difficulty in providing trained staff on a 24-hour basis and because of approaching summer holidays.

The staff nurses unanimously agreed to try the new system. The rotation, consisting of six twelve-hour shifts and one eight-hour shift every two weeks, enables us to have two fulltime nurses on each shift. Casual workers complete daily staffing, providing four RNs on days, three on evenings, and two on nights. No auxiliary personnel are employed in the unit.

After our six-month trial period, we have found more advantages than

drawbacks. The patient knows that his nurse during the evening will look after him throughout the night. This is particularly important to the patient who has just had a myocardial in-

Also, we can provide improved continuity of care since all the nurses involved discuss changes in patient eare or condition at least once a day. The third advantage for the patient is that care can be better geared to meet his requirements for sleep and rest.

For the staff, our rotation allows a long weekend every second week. This provides traveling time or time to be with families. Sick time has dropped to six days, compared with eighteen for the previous six months.

There are a few drawbacks, however. Two nurses have returned to an eighthour rotation, as they found twelve hours a health threat. During extremely busy periods, a nurse is exhausted after eight hours and her efficiency decreases. Performance during an "eleventh hour" crisis may be reduced. We try to have an extra person on duty during these peak periods.

As a result of the 12-hour shift, several changes have been necessary. Individual or small group discussions meet staff needs better than large general meetings. Once a month we have a staff meeting and allot time for a staff

development presentation.

There has been an improvement in staff morale and efficiency. Patients have also commented most favorably on our staff planning. — Andrea Fortin, head nurse, intensive coronary care unit, Cornwall General Hospital, Cornwall, Ontario.

Reunion for grads

A reunion is being held August 17, 18, and 19, 1973, for all graduates of Hotel Dieu Hospital in Chatham, New Brunswick. Anyone who has not been contacted should get in touch with me. -Patricia Kingston, 16 Nicol Street, Chatham, N.B.

Attention Sask. graduates

The alumnae of the Saskatchewan Institute of Applied Arts and Sciences nursing program in Saskatoon are active. We would like to begin publishing a newsletter to circulate to all graduates. In the future we would also like to have a reunion alumnae formal.

We need the help of the graduates of our school of nursing. Please send your names (including your maiden name) and addresses, as well as information or inquiries, to the secretary, Anita Sanderson, Apt. 7, 1017 Ave. C. North, Saskatoon, Sask. — Anita Sanderson, Saskatoon.

#### NEW POSEY DEVELOPMENTS

The new Posey products shown here are but a few included in the complete Posey Line. Since the introduction of the original Posey Safety Belt in 1937, the Posey Company has specialized in hospital and nursing products which provide maximum patient protection and ease of care. To insure the original quality product, always specify the Posey brand name when ordering.

The Posey Pelvic Seat effectively prevents sliding forward and falling from chair. This device is secured from behind on any type of chair and is comfortable for the patient. #4432 (cotton), \$7.50.



The Posey "Swiss Cheese" Heel Protector has new hook and eye fasteners for easy application and sure fit. Available in convoluted porous foam or synthetic fur lining. #6121 (fur lining), #6122 (foam), \$4.80 pr.



The Posey Body Stop Kit with soft padded bar provides a quick, simple, and effective method of preventing a patient from "scooting" forward in any standard wheelchair. #8155, \$24.95.





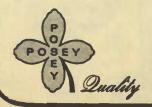
The Posev Houdini Security Suit is for the patient that will not stay in bed or wheelchair. Vest and lower portion interlock with waist belt making it virtually escapeproof. #3412, \$15.00 complete.



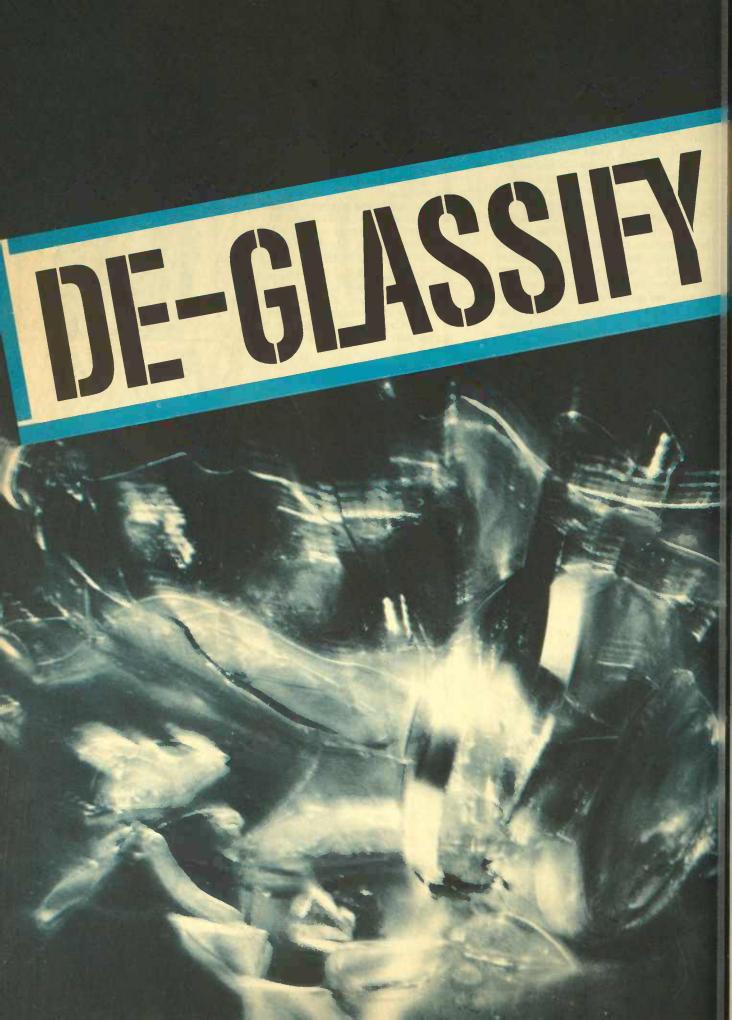
The Posev Foot-Guard with new "T" bar stabilizer simultaneously keeps weight of bedding off foot, helps prevent foot drop and foot rotation. #6412, \$21.00.

5end for the free all new POSEY catalog - supersedes all previous editions.

Please insist on Posey Quality - specify the Posey Brand name.



**POSEY PRODUCTS** Stocked in Canada ENNS & GILMORE LIMITED 1033 Rangeview Road Port Credit, Ontario, Canada



# TAKE THE BOTTLE PROBLEMS OUT OF YOUR IRRIGATION PROCEDURES WITH FLEXIBLE UROMATIC® PLASTIC CONTAINERS

DROP ONE. No breakage. No spillage. No dangerous mess... No cleanup.

FEEL HOW MUCH LIGHTER a plastic container with 3000 ml of solution is . . . 30% lighter than glass.

HANDLE THE SOFT FLEXIBLE CONTAINER. Note how easy it is to get a good grip on it—even when wet.

FORGET THE GLASS BOTTLE JUGGLING ACT. Changeover during surgery is accomplished easily and safely with the UROMATIC containers still hung in the in-use position.

NOTICE THAT THE SOLUTION HAS FEWER BUBBLES. This is a closed system. Air venting is not required so the urologist has greater assurance of a clear, bubble-free view through the scope during the procedure.

DISPOSE OF THE EMPTIES. Soft, flat, practically weightless, ready to drop into any nearby receptacle. Floors are free from the hazards and nuisance of empty bottles.

You probably have enough reasons right now to switch from bottles to the Baxter UROMATIC plastic containers. But here are just a few more. There's the time you don't spend cleaning up a mess of empty bottles or shattered glass. The fingers you don't cut on metal caps and glass fragments. There's the storage space you save with UROMATIC containers. They require approximately 30% less shelf space than glass. And then there's the extra dividend of better dispositions that come with DE-GLASSIFICATION.

So why stay stuck in the glass age, fighting the battle of the bottle? Why not talk to your Baxter representative today and discover how much easier life can be?



BAXTER LABORATORIES OF CANADA DIVISION OF TRAVENOL LABORATORIES, INC. 6405 Northam Drive, Malton, Ontario



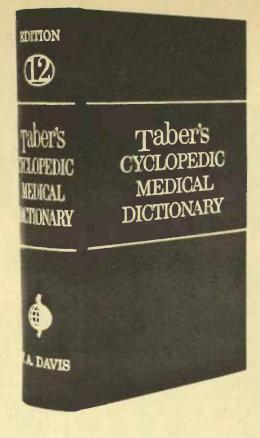
# it's the best one yet! the all new 12th Edition of TABER'S Cyclopedic Medical Dictionary

Ready Now! The new edition of Taber's Cyclopedic Medical Dictionary, rewritten, revised, and up-dated, puts more than 1700 pages of facts at your fingertips. It is a current and accurate source of contemporary medical knowledge...one of the most reliable reference works in print for professionals in all areas of health care.

**Nearly 1200 new words** reflect recent advances in medicine and its terminology.

More than 40,000 entries were checked for scientific accuracy. Many were completely rewritten or extensively revised. Those no longer used or useful were removed from the dictionary.

The new type is larger, sharper, more readable. Use of a computer to set type let us make corrections and additions right up to the last minute...so you know Taber's is as up to date as any printed work can be.



Metric, as well as English, System Units are given for all weights and measures.

Poison Control Centers in the United States and Canada are listed in the Appendix.

Plus these features you've always relied on: Pronunciations (for more than 90 percent of the words); Etymologies (Taber's is the only dictionary of its type to give word derivations!); Prefixes; Suffixes; Medical Synonyms.

1973; 1754 pages; \$9.60 plain, \$11.40 thumb-indexed;

ALSO PUBLISHED IN 1973 —

#### CONCEPTS BASIC TO NURSING

Pamela Mitchell

1973; 384 pages; \$9.85

Designed for the first course in nursing for all baccalaureate and many associate degree nursing schools. This text is meant to provide concepts and tools for a systematic approach to diagnosis of the patients' needs and for planning and providing appropriate nursing interventions for the person's problems in coping with daily living.

#### CONTINUING NURSING EDUCATION

Signe S. Cooper, May S. Hornback

1973; 275 pages; \$10.95

Rapid technological changes, the specialization of nurses after graduation, and the shortage of nurses have contributed greatly to the expansion of inservice continuing education programs. This book includes a consideration of current trends and developments in continuing education in nursing.

#### **PSYCHOSOCIAL NURSING CARE OF THE AGED**

edited by Irene M. Burnside

1973; 228 pages; \$5.45

This symposium gives specific methods for psychosocial nursing care of the aged, especially the impaired aged. Communication with the aged is disussed in Part One. Parts Two and Three take up a wide variety of problems associated with old age and with nursing geriatric patients. Group work with the aged in various settings is the subject of Part Four.

**College Division** 

McGraw-Hill Ryerson Limited

330 Progress Avenue

Scarborough, Ontario

M1P 2Z5

#### news

#### CNA, CMA, CHA Joint Committee **Presents Brief To Health Minister**

Ottawa — Health and Welfare Minister Mare Lalonde met with the presidents and executive directors of the Canadian Nurses' Association, Canadian Medical Association, and Canadian Hospital Association February 19 to discuss their brief on health care and the cost of health services.

The brief, which resulted from the September Health Action '72 conference at Mont-Gabriel (News, November 1972, page 9), was prepared by the joint committee of the three associations for the federal and provincial health ministers. It stressed close cooperation between the three major voluntary health associations and government to solve the problems of rising health care costs and deficiencies in the present system of providing health services.

Mr. Lalonde did not agree to a request in the brief that the joint committec be made an official advisory body to him; he explained he already has a number of advisory committees. However, he said he would consult with the committee members, either as a group or individually, when necessary over the next few years.

In its emphasis on provincial action, the brief said: "The three associations will strongly urge their respective provincial divisions to establish joint committees similar to the one at the national level and will suggest that these committees be recognized as official advisory bodies to the provin-

cial ministers of health.'

Mr. Lalonde said that action must come from the provinces, and he encouraged more conferences, such as Health Action '72, at the provincial level.

Copies of the brief were sent to the provincial ministers of health before their conference in Ottawa at the end of March. Executive directors of the provincial health associations also received copies before the ministers' March meeting.

#### Nurses Across Canada Plan **Four Panels For ICN Congress**

Ottawa — On the afternoons of May 16 and 17 during the ICN Congress in Mexico City, Canadian nurses will be



The president and executive directors of the Canadian Nurses' Association. Canadian Medical Association, and Canadian Hospital Association met with Health and Welfare Minister Marc Lalonde in February to present a joint brief. From left to right are Marguerite Schumacher, CNA president; Mr. Lalonde; Judge E.N. Hughes, CHA president; and Dr. Gustave Gingras, CMA president.

presenting four panels — two in English and two in French.

Dr. Helen K. Mussallem, executive director of the Canadian Nurses' Association, will moderate the panel dis-cussing "New Sensitivity in the Process of Communication." Participants on this panel will be Dr. Josephine Flaherty, president of the Registered Nurses' Association of Ontario, who will talk about communication among nurses; Jean Pipher, president of the Saskatchewan Registered Nurses' Association, who will talk about communication between teacher and students; and Margaret S. Neylan, president of the Registered Nurses' Association of British Columbia, who will talk about communication among members of the health professions.

A panel on "Research and Reality: Implementation of Nursing Research in Education and Practice" will be presented by British Columbia and Alberta nurses. Co-chairmen of the panel will be Dr. Shirley M. Stinson, professor in the division of health services administration at the University of Alberta, and Mary Richmond MacBean, director of nursing at Vancouver General Hospital.

Members of the research panel will be Susan Rothwell, Instructional Resources Centre, University of British Columbia; Patricia Hayes, coordinator of the advanced practical obstetrical program at the University of Alberta school of nursing; and Margaret Steed, the University of Alberta's consultant to the schools of nursing in the prov-

Four nurses from Quebec will present a panel on "Le Role De L'Infirmière Dans l'Evolution Sociale." The moderator will be Rita Dussault, director of the school of nursing at Laval University in Quebec. Those participating as panel members will be Nicole Du Mouchel, executive director and secretary-registrar of the Association of Nurses of the Province of Quebec; Rachel Bureau, president of

**APRIL 1973** 

#### news

ANPQ,; and Sr. Anicette Guay, director of nursing service at St-Joseph

Hospital in Three Rivers.

"Relations Infirmière-Malade: Perceptions, Attitudes, et Communications" is the topic of the second Frenchlanguage panel. Madeleine Corbeil, professor at Laval University in Quebec City, will be the moderator. Panel members will be Cécile Boisvert, clinical nurse specialist in St-Léonard; Janine Drapeau, Laval University Hospital Centre; and Michelle Charlebois, assistant professor, Montreal.

As of the beginning of March, 352 nurses in Canada had registered for the ICN Congress. The numbers from each province are: Ontario — 102; Alberta — 82; Quebec — 72; British Columbia — 51; Manitoba — 14; Saskatchewan — 10; New Brunswick — 9; Nova Scotia — 7; Newfoundland — 4; and Prince Edward Island — 1.

Government Issues Stamp To Honor Jeanne Mance

Ottawa — April 18 is the day the Canadian Post Office has chosen to issue an eight-cent stamp honoring Jeanne Mance, North America's first secular nurse. Jeanne Mance was the founder of the first hospital in Ville Marie and one of the founders of the settlement in 1642. That first hospital, built of wood outside the fort, was the beginning of Montreal's Hôtel-Dieu Hospital.

At the age of 34, Jeanne Mance (1606-1673) left her native town in France, where she had helped many sick and wounded, to go to Canada. But before she left her country, she visited Paris. There she received religious encouragement and financial support for a hospital in New France. The sponsors of the Montreal undertaking, who included some of the wealthiest and most influential women in Paris, were behind her.

Although she was never in good health and suffered a serious arm injury in the winter of 1657, Jeanne Mance lived through the hardships of climate and Indian raids, administering her growing hospital in Ville Marie until her death. On a number of occasions, she made the difficult trip back to France to obtain more support for the settlement.

To celebrate the 300th anniversary of the death of Jeanne Mance, the Hôtel-Dieu Hospital in Montreal has planned an exciting program of events.



Jeanne Mance

The program began in February, with the opening of an exhibition of authentic objects and documents from the historic archives of the Religieuses Hospitalières de Saint-Joseph in Montreal; launching of the book L'Hôtel-Dieu de Montréal, 1642-1973, written by history professors and students at the universities of Quebec, Montreal, and Ottawa; and première of a 16mm, color film on the history of the hospital.

On May 15, an exhibition of photographs showing Hotel Dieu "from yesterday to today" will be opened. Two days later an official tribute will be paid to the hospital's founder. This will consist of a Mass, a blessing of the hospital's first flag, raising the flag at the Jeanne Mance monument on Pine Avenue, buffet, visit to the exhibition of historic objects, showing of the film, and reception given by the City of Montreal.

Ålso in May, there will be a celebration on the 18th of the founding of Montreal. On the 19th, a number of events are planned: guided visits to the hospital, exhibition, crypt, and gardens; film of the hospital; round table discussion on the role of the chaplain on the health team; awarding of prizes in the photograph-fine arts competition; and a Gilles Vigneault show.

RNABC Seeks Bargaining Rights For RNs In Civil Service

Vancouver, B.C.—The Registered Nurses' Association of British Columbia is seeking jurisdiction for some 600 registered nurses employed by the provincial government.

The association's stand was given in a brief presented in November 1972 to a government-appointed inquiry commission that is looking into full bargaining rights for civil servants in the province. In another brief to the commission, the B.C. Government Employees Union asked for jurisdiction over all civil servants.

RNABC's 12-page brief called for continued recognition of the association as bargaining agent for the province's RNs, regardless of where they are employed. It pointed out that for many years the association has been recognized by the government as the spokesman and consultant for nurses employed by the B.C. government, and it wishes to continue providing

this leadership.

Nora Paton, director of personnel services for RNABC, stated in the brief that "RNABC has on a number of occasions presented briefs to the Civil Service Commission on behalf of nurse employees. In addition, the association has acted in an advisory and consultant capacity to those nursing groups who have presented salary briefs yearly to the Civil Service Commission."

RNABC has been prepared to fund any nurse employee group in the Civil Service so the group could present demands on salary and working condi-

tions, Ms. Paton noted.

The association's brief also supported collective bargaining rights for civil servants, including the right to strike. "While the RNABC has never exercised the right to strike, which it presently has, it is unwilling to give up this right without some other guarantee of a piece of artillery in the collective bargaining procedure. To give up such a right would remove a great deal of the impetus to concluding an early and favorable settlement in contract disputes. We know of no other substitute for that right."

Master Of Health Sciences Program Will Prepare Nurses At McMaster

Hamilton, Ont.—A Kellogg Foundation grant of over \$290,000, awarded to the division of health sciences at McMaster University, will help the school of nursing develop an interdisciplinary graduate program to prepare nurses for advanced clinical practice in primary and ambulatory care.

The graduate program will lead to a master of health sciences degree, designed to educate leadership personnel for a variety of health professions. Initially, these will include nursing, physiotherapy, and occupational therapy. The first students are expected

(Continued on page 14)

**APRIL 1973** 



Every good nurse knows how to soothe a baby but...

not every nurse knows that by recommending new faster acting Ovol Drops she can help give more rapid relief to infants suffering from bloating, infant colic and flatulence from entrapped gas. But the word is spreading. More and more qualified nurses are recommending new Ovol

Drops as the fast acting antiflatulent that's intended for infant use.
We'd like you to remember Ovol
Drops the next time you have to recommend an antiflatulent to a worried mother for her baby.
She'll thank you for it.

\*Reg. T.M. Frank W. Horner.



# UROGATE\* The total system to meet all your irrigating requirements

Solutions
Administration sets
Drainbox\*\*

Now with the Urogate System you can choose from four handy big-mouth bottles.

You'll like the new 500 ml. and 1,000 ml. sizes. They're just right when you need smaller volumes of pour solutions.

Or, where you need *larger* volumes, the familiar 1,500 ml. and 3,000 ml. Urogate containers are ideal.

Those generous 38-mm. openings are built for business! For example, you can empty the new 1,000 ml. bottle in 10 seconds. Or empty the 500 ml. bottle in just 7 seconds.

(Or, when you choose, pour a slow, carefully regulated stream.)

No mix-up with I.V. bottles on your shelf either: you can recognize the distinctive Urogate shape at a glance. What's more, these bottles accept only Urogate urologic sets. No chance of accidental intravenous infusion.

You'll find a choice of Urogate solutions and sets for all your surgical and urologic irrigating needs. It will be worth your while to learn the details. Why not talk to your Abbott Representative this week.

### **Urogate**



#### news

(Continued from page 10)

to be admitted September 1973.

This program will concentrate on advanced clinical practice for expert practitioners who want to prepare for positions as teachers, researchers, and consultants. Required courses will be in the health care system, applied behavioral science, and research Added methodology. courses advanced clinical practice will be geared to the student's basic preparation and career interests.

Advanced study for nurses is planned in primary care and maternalchild nursing. Students will also be able to choose elective courses in health systems management or cur-

riculum development.

Dr. Ruth MacKay, associate professor in the McMaster school of nursing, will direct the graduate program. For applicants with a clear admission and no prerequisites to fill, the program will likely take three terms, or approximately one and a half calendar years. Applicants without an academic degree will be assessed on universitylevel work completed, work experience, leadership potential, and career goals.

There is no similar program in Canada. It will be one of at least three graduate programs that will share common courses and draw on a variety of academic and clinical resources

not available at McMaster.

The funds for this program will be supplied over four years by the W.K. Kellogg Foundation of Battle Creek, Michigan. The Foundation, which assists educational programs in health, education, and agriculture on four continents, is concerned with training health manpower in medicine, nursing, dentistry, and allied health fields. Its probelm-solving concerns in health include new community health systems, emphasizing quality, cost containment, and improved access and availability.

#### Car Care And Wilderness Survival In Australian Nurses' Course

Perth, Australia — Some Australian nurses are studying transport, radio communications, aeronautics, survival, and self-defense.

These subjects are compulsory for public health field nurses in the community health services section, public health department of the state of Western Australia.

The course in field skills is an

addition to a new public health nursing course run by the College of Nursing, Australia, for nurses studying in Western Australia.

The extra field skills course takes 12 weeks in addition to the 28-week postgraduate course in public health nursing. Included in the field skills is basic care and understanding of a car so that a nurse is better able to cope if a vehicle fails when she is many kilometers\* from help. Knowledge of radio communications and aeronautics will help the nurse in liaison with the Royal Flying Doctor Service on which she can call.

The last two subjects, survival in the outback and self-defense, will not have

wide application, it is hoped.

The senior medical officer of the community health services fists the area's most prevalent endemic diseases: leprosy, yaws, hookworm and other parasites, trachoma, gastroenteritis, scabies, and lice. The most prevalent disease of all is malnutrition.

Provision of health services in Western Australia is no easy task because of the size of the state — 1,600,000 square kilometers; widespread and scanty distribution of population in the outer, or outback areas; and extremely harsh traveling and living conditions.

"One job might require a nurse to drive hundreds of kilometers through thick sand or over rocks and ridges in temperature around 40°C. in order to get to a family or a community where she is needed," the doctor said.

Other difficulties arise when epidemics hit isolated communities. A single nurse, who can carry limited supplies and medicines, may go to see a single Aboriginal person with a severe cold and find the whole tribe suddenly comes down with influenza. \*Australia has adopted the metric system; Canada will do so. If you don't understand the metric measures mentioned, look them

**RNABC Brief Urges Program** To Prepare Nurses For New Roles

Vancouver, B.C. — A brief presented February 14, 1973, to the director of the Health Security Program project in British Columbia recommends an expanded role for nurses in primary care and nursing representation on all health care planning bodies.

A delegation from the Registered Nurses' Association of British Columbia, headed by RNABC president Margaret Neylan, presented the brief, which urges early implementation of a proposal for an educational program

to prepare the nurses.

The program proposal was prepared

(Continued on page 18)



fy size under COLOR column

soft breathing Imperial Cush new Pill-O-Puff cushioned seam v Pitt-0-Putt custioned seam tongue. Longitudinal and tarsal arch support, arch v for day-long freshness, easy-care white wash leather. Fit guarantee return (unmarred size excha

. . . 15.00

New Kork-Lites Featherweight Style

New ROTK-Lates Feathers
An extremely lightweight professional
walker, with the new "bottom" look.
Smart, comfortable lace-up heel
oxford over bumper toe last. Thick
simulated cork sole with 1½"
cork heel (very slip resistant,
and outlewars crepe). Styled
in white washable solt
elive unper leather glove upper leather, tricot-lined, with arch vents. The very latest ... reflecting trends in today's fashions. Fit guaranteed or return (upmarred)

(Specify size under CDLOR column return (unmarred) for size exchange.

No. 638 Kork-Lite Shoe

All-Weather NURSES' CAI

Stay snug in cool weather, dry in the Traditional Navy with Bright Red lif-Finest tailoring of 65% Oacron polyer 35% combed cotton. Zepel treated. 1( Nyion Duralyn lining. Snap fasteners, openings. Matching head sacri. Wash warm water, tumble dry and smooth. Sh (up to 34 bust). MEDIUM (35-38) or L4 (39-42) ... specify size on coupon u "COLOR".

No. 658 Cape . . . . . . 14.95 6-11 13.95 ea., 12 or more 12.95 3 Gold Initials inside collar, add 1.00 per a

#### Cobbler-Style TUNIC

Pretty and perky over uniform, pants, skirt or dress . . . serves many needs. 200 dnr. washable Nylon Taffeta. 29" long, 20" wide. Huge, handy oversized pockets. Choose all snow-white . . . or aqua or red with black trim.

No. 360 Tunic . . . 4.98 ea., 6 or more 4.50 ea. 2 Geld Initials en pocket, add 50¢ per tunic.





#### Nurses' POCKET PAL KIT

Handiest for busy nurses. Includes white De Pocket Saver, with S" Bandage Shear (both sh opposite page), Tri-Color bail-point pen, handsome little pen light . . . all silver finis Change compartment, key chain.

No. 291 Pal Kit . . . . . . 4.95 3 Initials engraved on shears, add 50¢ per ki

#### **Endura STOPWATCH**

A fine Swiss instrument for critical timing. Records to 1/10 second (2 full revolutions per Records to 1/10 second UZ full revolutions per minute). Anti-magnetic, guaranteed accurate. Numerals red and black on white face. Top button starts/slops; side button returns to zero. Grey Cycolac molded case, serrated griptight edge. 18" red neck loop

No. 15-129-1 Stop Watch . . . 19.95 ea. 3 angraved initials on back, add 1.00 per watch.





#### Pull-Out KEY-KEEP!

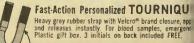
End fumbling for keys! Pin key-keeper on form or in bag. Attach keys to bead chain. out to use key, rewinds automatically. No convenient. Silver finish. In plastic gift c No. 155 Keeper . 2.49 6-11.2.25 ea. 12 or more, 2.00 ea. 3 initials angraved, add 50¢ per Kee

#### Brass DOOR NAMEPLATES

Trim, distinctive and helpful for callers. Your Name engraved and lacquered into smart solid brass 2½" doorplate. Salin gold with polished border, weather-proof finish, black lettering. Brass nails lackled.

MR & MRS. DONALD HANSCOM THE HOLBRU

No. 701 Doorplate . . . 1.98 ea.
Print name desired clearly on separate paper.



THE CANADIAN NURSE No. 641 Tourniquet . Duty free . 2.69

# Name Pins...and Other Nice Things...from Reeves

Reeves Name Pins . . . most popular among nurses! Superb quality, smartly styled, with sharp, clear names deeply engraved.

#### IT'S EASY TO ORDER REEVES NAME PINS FOR YOURSELF OR FRIENDS!

Choose style you want, shown right. Print name (and 2nd line if desired) on dotted lines below. Check other into in boxes on chart, clip this section and attach to coupon

bottom right. Attach extra sheet for additional pins. NOTE SAVINGS DN 2 IDENTICAL PINS . . . more convenient,

2nd LINE: BACKEROUNG COLDR (Plastic) PRICES. LETTERINS COLOR DESCRIPTION Engraved 1 Line | Engraved 2 Lines ALL METAL . . . rich, trim and tailored. Lightweight, smooth edges, rounded corners. Polis! Does Black
Dk. Blue
White ☐ 1 Pin 1.98 ☐ 1 Pin 2.58 ☐ Gold 169 Silve Satin 2 Pins 3.25 2 Pins 3.85 apply PLASTIC LAMINATE . . . slimmer, broader; engraved thru surface to contrasting core color. Beveled border matches lettering. ☐ White Does Does CT 1 Pin .95 T 1 Pin 1.45 Med. Gree Med. Blue 559 2 Pins 1.65 2 Pins 2.30 (same name) White Letters on apply apply METAL FRAMED ... with sno white plastic center. Smooth beveled edges. Gold Silve Black 100 frame only smart, will never discolor. Rounded corners and edges. Does 1 Pin .95 1 Pin 2 Pins 1.65 2 Pins White 510 apply

Plaase add 25¢ per order for 3 pins or less

QUANTITY DISCOUNTS: 10-24 pins, deduct 10%; 5-99 pins, 15%; 100 or m

# MRS. R. F. JOHNSON SUPERVISOR CHARLENE HAYNES

MRS. HOLBROOK ANN COHN, L.P.N.

Framed No. 150

All White Plantin No. 510

BANDAGE SCISSORS Personalized, precision-made forged Lister scissors, Guaranteed 2 years.



Tiny, handy, slip into uniform pocket or purse. Choose jewelers Gold or gleaming Chrome plate finish on coupon.

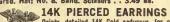
41/2" or 51/2" SCISSORS

above, but larger for biggar jobs. Chrome finish only. Choose No. 3500 (3½"), No. 4500 (4½") or No. 5500 (5½") . . . 2.75 ms. 1 Gez. ar more . . . \$2.00 ms. Your initials angrayed, add  $50_g$  per acissers.

#### JEWELRY

#### NURSES CHARMS

Finest sculptured Fisher charms, 
Sterling or Gold Filled (specify under CDLOR on coupon).
For bracelet or pendant chain. Add to your collection!
No. 263 Caducaus; No. 164 Cap; No. 68
Grad. Hat; No. 8. Band. Sciasors . 3.49 ma.



Dainty, detailed 14K Gold caduceus, for on or off duty wear. Shown actual size. Gift boxed for friends, too.

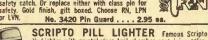
wear. Shown actue.

No. 13/297 Earrings

PIN GUARD Sculptured caduceus, chained letters, each with pinback/

Page 80, LPN

Change 8N, LPN





Vu-Lighter with crystal-clear fuel chamber containing color-ful array of capsulas, pills and tablets. Novel, unique, for yoursell or for unusual gifts for friends. Guaranteed by Scripto. A real conversation piece! No. 300-P Pill Lighter . . . .

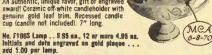


POCKET SAVERS
Prevent stains and weer!
Smooth, pliable pure white vinyl, Ideal low-cost group gifts or favors.
No. 210-E (right), two compertments with flap, gold stamped caducuss...
E for 1.50, 25 ar more 20 a.

No. 791 Goft Deluxe Saver, 3 compt., change pocket & key chain . . . 6 far 2.00, 25 or more 35, ma.

#### NIGHTINGALE LAMP

An authentic, unique favor, gift or engraved award! Ceramic off-white candleholder with genuine gold leaf trim. Recessed candle cup (candle not included). 7" long.



#### NURSES WATCHES Hamilton 17 Jowel



CDMD

"Buren" Calendar Watch, 17 jeweis, sweap-second hand. Date changes at midnight. Water, shock resis., anti-mag, unbrask, mainspring. Chrome finish, expen. bracelet, 1 yr, guerantee. No. BL53 Ham. Watch . . . 34.95 ea.

Endura Waterproof Swiss made, raised silvar full numerals, lumin. markings. Red-tipped sweep second-and, chrome/ stainlass case. Includes genuine block reather watch strap. I year guerantee. Very dependable.

No. 1093 Endura Watch . . . . . . . . . . . . . . . . . . 29.95 ma.

BZZZ MEMO-TIMER Time hot packs, heat lamps, park meters. Remember to check vital signs, give medication, etc. Lightweight, compact (1½" dis.), sets to buzz 5 to 60 min. Key ring. Swiss made. No. M-22 Timer . . . . . 3.98 mm. 3 for 9.75 , 6 or more 3.00 mm.



#### EXAMINING PENLIGHT

White barrel with caduceus imprint, aluminum band and clip. 5" long, U.S. made, batteries included (replacement batteries available any store). Your own light, gift boxed. No. 007 Punlight . . . 3.95 us. Your Initials sograved, add 50s per light.

Natalie B. Harens CROSS PEN

World-famous ballpoint, with sculptured caduceus emblem. Full name FREE angraved on barrel (include name with coupon). Refills avail. everywhere. Lifetime guarantee.

MEDI-CARD SET Nondiest reference ever! 6 smooth plastic cards (3½" a 5½") crammed with information, including Equivalencies of Apothecary to Metric to Household Meas, Tamp. °C to °F, Prescrip, Abbr., Urinelysis, Body Chem., Blood Chem., Liver Tests, Bone Marrow, Gisease Incub, Pariods, Adult Wets., Child's Ossages, etc. All in white vinyl holder with gold stamped caduceus. No. 289 Card Set . . . 1.50 oa. 6 or more 1.25 aa. 22 or more 2.10 ea. Your initials gold-stamped on holder, add 50¢ par set. KELLY FORCEPS So handy for every nurse! 5½" stainless steel, fully guaranteed, Ideal for clamping off tubing. Your own initials help prevent loss. CAR



#### Free Initials and Scope Sack with your own Littmann Nursescope

diaphragm stethoscope . . . a fine precision instrument,

with high sensitivity for

with high sensitivity for blood pressures, apical pulse rate. Only 2 ozs., fits in pocket, with gray vinyl anticollapse tubing, nnn-chilling epoxy diaphragm. 28" overall. Non-rotating angled ear tubes and chast piece beautifully styled in choice of 5 jewel-like colors: Goldtone, Silvertone, Blue, Green, Pink."

FREE INITIALS AND SACK! Your initials engraved FREE on chest piece; lend individ-

ual distinction and help pre uar distinction and help prevent loss. Also FREE SCOPE SACK included, worth \$1. as described above right. (Free sacks not personalized; add 50¢ if initials desired.) Ideal



No. 216 Nursescope.

for group gifts! Note big sav-ings on quantity orders (left). 13.80 ea. ppd.
6-11...12.80 ea. 12 or more ...11.80 ea.
Group Discounts include free initials and Sack! "IMPORTANT NEW FEATURE: New "Medallion" styling includes tubing in colors to match metal parts. If desired, please add \$1. ea. to all prices above, and add "M" to Order No. (No. 216M) on coupon.

Duty free

No. 3502 Chrome B.00 ea. No. 6602 12kt. G.F. 11.50 ea. COMPLETE SATISFACTION GUARANTEED! All prices postpaid. Please allow sufficient time for delivery.



SCOPE SACK neetly carries and protects Nursescope or any scope. Double-thick trosted flexible plastic, white vinyl binding. 4½" x 9½". Your own initials help prevent loss. No. 223 Sack. . . 1.00 na. 8 pr more 75s na. Your initials guid-stamped, add 50s per sack.

#### NURSES PERSONALIZED ANEROID SPHYG.





#### CAP ACCESSORIES

(NAJ) CAP TOTE keeps your caps crisp and clean while stored or carried. Flexible clear plastic, white trim, zipper, carrying strap, hang loop. Stores flat. Also for wights, curiers, atc. 8½" dra., 6" high.

No. 333 Tote . . 2.65 ma., 6 or more . . 2.35 ea. Your initials gold-stamped, add 504 per Yote.



WHITE CAP CLIPS firmly in place! Hard-to-find white bobbie pins, enamel on fine spring steel. Eight 2" and eight 3" clips included in plastic snap box.
No. 529 Clips . . 3 boxes for 1.95, 6 for 3.25, 12 for 49¢ ea.

#### MOLDED CAP TACS

Replace cap band Instantly. Tiny plastic fac, dainty caduceurs. Choose Black, Blue, White or Crystal with Gold Caduceus; or all Black (plain). The neater way to festen bands. No. 200 Set of 6 Yess ... 1.25 per set. 12 or more sets 1.00 per set





IU: RELYES COMPANT, DUX /15, ALLIEBUTU, MASS. UZ705						
ORDER NO.	ITEM	COLOR	QUANT.	PRICE		
		1				

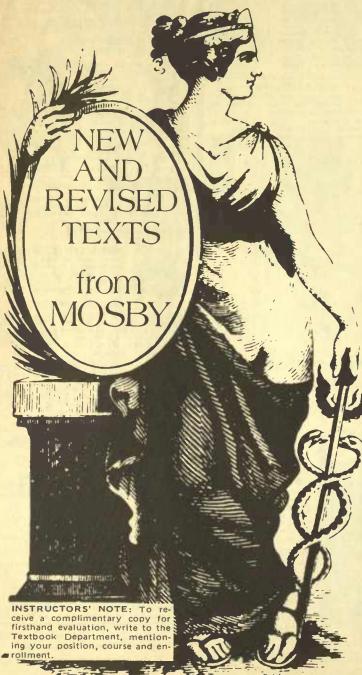
use	extra	sneet	tor	9001	tionai	items	91	prders.	

INITIALS as desired: Good idea . . . for distinctive identification)

TO OROER NAME PINS, fill out all information in box top left, clip out and attach to this coupon.

I enclose \$Sorry, no COD's or	
Send to	 
Street	 

# CLASSICS IN THE MAKING



#### CLINICAL EXPERIENCE RECORD AND NURSING CARE PLANNING -

#### A Guide for Student Nurses

Here's a unique guide to practical organization of material and patient studies in clinical nursing. It outlines your student's expected learning experiences and records those which she has acquired. By helping you find students' strong and weak points, the book enhances the meaningfulness of

By SISTER MARY THOMASINA FUHR, R.N., M.S.N. November, 1972. 134 pages plus FM I-X, 71/4" x 101/2".



A New Book!

Auld-Birum

#### THE CHALLENGE OF **NURSING: A Book of Readings**

This broad overview incorporates philosophical, conceptual, and practical aspects of your students' chosen profession. The five units present topics selected from original publications by more than 30 leaders in the nursing field. The anthology covers the definition and nature of nursing, psychological diagnosis and the nurse's involvement in her work.

By MARGARET E. AULD, B.S., M.N., R.N.; and LINDA HULTHEN BIRUM, B.S., M.N., R.N.; with 38 contributors, January, 1973. 247 pages plus FM I-XIV, 6½" x 91/2". Price, \$5.20.



New 5th Edition!

Squire-Welch

#### BASIC PHARMACOLOGY FOR NURSES

Your students will appreciate this source of vital information . . . designed to help them fulfill their role in the administration of drugs. Basic information covers the effects, dosages, and usages of common drugs; and notes weights, measurements, and abbreviations used in medicine. Chapters new to this edition discuss: anesthetics; hallucinogenic drugs; serums and vaccines; and antineoplastic

By JESSIE E. SQUIRE, R.N., B.A., M.Ed.; and JEAN M. WELCH. R.N., A.B., M.A., B.S.N.Ed. March, 1973. 5th edition, 370 pages plus FM I-XII, 74" x 104", 20 illustrations in 9 figures. Price, \$6.05.



#### NUTRITION AND DIET THERAPY

Here's an all-inclusive classroom package for you! In revising this book, the author says, "Two basic objectives have prevailed: clarity of content and person-centered focus." To this end, she emphasizes application of nutritional science principles to specific clinical situations and individual needs. Watch for new material on hyperlipoproteinemia, nutrition during pregnancy and lactation, and problems in control of food additives.

By SUE RODWELL WILLIAMS, M.R.Ed., M.P.H. February, 1973. 2nd edition, 694 pages plus FM 1-XVIII, 7" x 10", 124 illustrations in 117 figures. Price, \$11.05.



New 2nd Edition!

Williams

#### NUTRITION AND DIET

THERAPY — A Learning Guide for Students "Survival strategies . . . " "open systems . . . " "We

must be innovators rather than unthinking conformers." All key ideas in Part 2 of the Williams nutritional package. Designed to supplement the text described above, this guide presents information in three parts: AN APPROACH TO LEARN-ING - Suggestions and techniques for study, problem-solving; FOUNDATION OF NUTRI-TION - A study guide for normal nutrition; and APPLIED NUTRITION - Clinical case studies.

By SUE RODWELL WILLIAMS, M.R.Ed., M.P.H. February, 1973. 2nd edition, 186 pages plus FM 1-X, 7½" x 10½". Price, \$5.25.



A New Book!

Williams

#### REVIEW OF NUTRITION AND DIET THERAPY

#### (Mosby's Comprehensive Review Series)

And finally, Part 3: a broader coverage of nutrition, that allows your students to see not only their roles, but also nutrition as it relates to all health care professionals who meet patients in a variety of community and clinical settings. The text is organized in effective question-and-answer format, touching on water and electrolytes, food habits, child and adult health problems . . . the entire nutritional spectrum, from basics to spe-

By SUE RODWELL WILLIAMS, M.R.Ed., M.P.H. February, 1973. 293 pages plus FM 1-X, 7" x 10", 40 illustrations. Price, \$8.70.

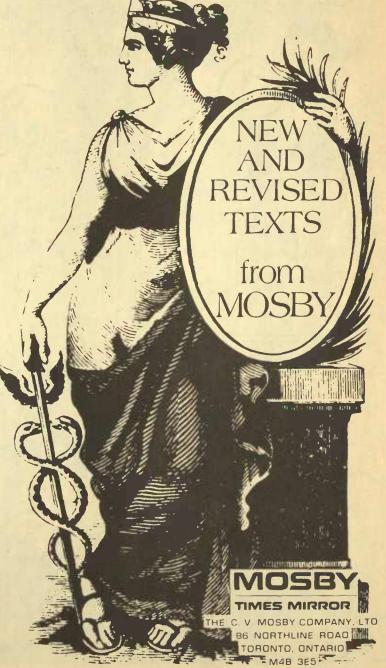


A New Book! THE SURGICAL PATIENT -

Behavioral Concepts for the Operating Room Nurse

"We envision the OR nurse fulfilling the vital role in the continuity of care of the patient undergoing surgery." The authors' vision comes alive for your students in a text that explores (for the first time in depth) surgical conscience. It teaches a solid OR framework by emphasizing principles - at the same time weaving in techniques that put the principles to use. However, the book is organized so that the nurse is left free to choose her own preferred nursing action.

By BARBARA J. GRUENDEMANN, R.N., B.S., M.S.; SHIRLEY B. CASTERTON, R.N., B.S.; SANDRA C. HESTERLY, R.N., A.A.; BARBARA B. MINCKLEY, R.N., B.S., M.S., D.N.Sc.; and MARY G. SHETLER, R.N., B.S.N. May, 1973. Approx. 205 pages, 7" x 10", 65 illustrations. About \$5.75.



#### news

(Continued from page 14)

by the University of British Columbia school of nursing at the request of the provincial joint committee on the expanded role of the nurse in the provision of health care. It has been submitted to B.C. health minister Dennis Cocke.

Representation on the joint committee, chaired by Alice Baumgart,

is from the province's College of Family Physicians, Medical Association, College of Physicians and Surgeons, department of health services, school of nursing and faculty of medicine at UBC, diploma schools of nursing, and RNABC. The coordinator of health sciences at UBC and a nurse practicing in an expanded role are also on the committee.

Ms. Neylan said nurses working in expanded roles in community settings and remote areas are graduates of traditional programs, who have broadened their skills mainly through their own effort.

"We're now ready in British Colum-

bia to provide more effective additional preparation through short courses for practicing nurses on a province-wide basis. It has been recommended that additional preparation for student nurses be provided through modification of current nursing education programs."

The RNABC president added: "We need a framework within which the registered nurse with appropriate educational preparation and experience can freely practice as a provider of primary care to the people of British

Columbia.'

RNABC's brief contains 15 recommendations dealing with various aspects of health services involving nursing care and health education of the public. The brief states the need to plan for transferring appropriate functions from highly skilled, highly paid professionals to other health workers. The association says this is necessary if the goal of increased productivity and effectiveness of health professions is to be achieved.

The RNABC hopes provincial funding will enable the proposed program to begin in 1973. Cost of the program for 1973 is estimated at \$72,000.

Arbitration Backs Nurse's Claim To Bonus For Midwifery Course

Hamilton, Ont. — In this first case of its kind in Ontario to be taken to arbitration, an arbitration board has upheld a nurse's claim for a \$15 a month allowance for having completed part 1 and part 11 of her midwifery course in the United Kingdom.

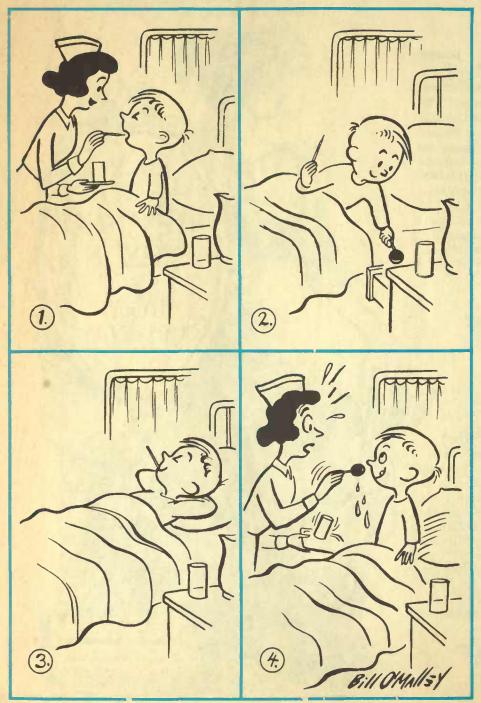
The nurse, who works in the maternity department at St. Joseph's Hospital in Hamilton, Ontario, claimed in her grievance that the hospital violated the provision of the collective agreement, which granted such an allowance "for approved special clinical preparation of three months or more... when such skills are used directly in the work assigned."

Refusing the payment on the grounds it had not approved the midwifery course, the hospital justified this by stating the practice of midwifery in Ontario is restricted to the medical profession.

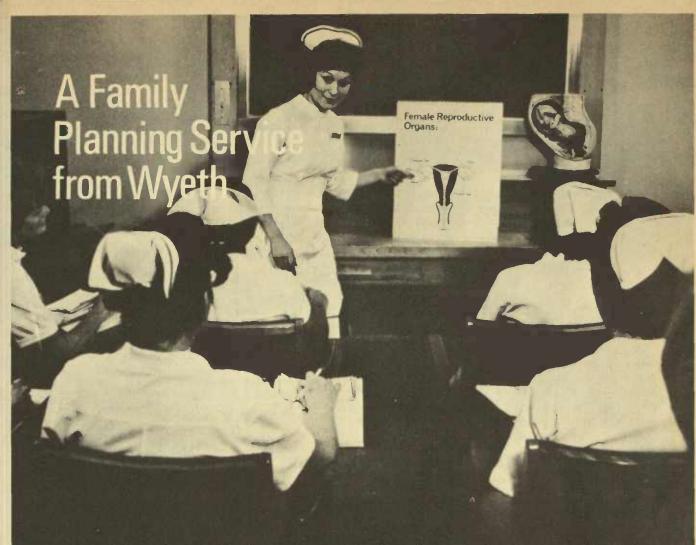
The January 1973 employment relations newsletter of the Registered Nurses' Association of Ontario outlined the arbitration board's arguments in

favor of the nurse's claim.

In its conclusion, the board noted: "The fact that the grievor in her work as a registered nurse would not exercise the responsibility of a midwife...does not [detract] from the substantial training in obstetrical nursing...[she] received.... To recognize the grievor's



(Continued on page 20)



Supervisors, teachers, family planning organizations—can now take advantage of Wyeth's complete Family Planning Service.

Wyeth makes available to you: large flip charts useful for teaching birth control methods to groups; smaller, handy booklets with illustrations corresponding to the flip chart; a film library service, including the widely popular "Happy Family Planning" (five languages shown on the film: English, French, Italian, Chinese, Arabic); and "Question and Answer"

booklets about oral contraception, with reference to Ovral\* 21's and 28's. All are available to recognized groups through your Director of Nursing, Supervisor, or Doctor.

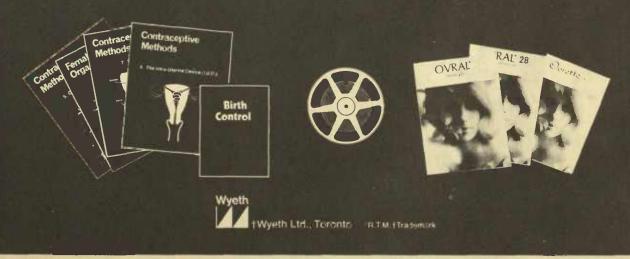
Simply write, stating the nature and size of your group, and your requirements:

Director of Family Planning Services

Wyeth Ltd.

4455 Chesswood Drive

Downsview 461, Ontario



#### news

(Continued from page 18)

courses of study is not to recognize midwifery, but . . . recognize the value for an obstetrical nurse of advanced training in obstetrical nursing subjects."

The board also considered the fact that the hospital had agreed to pay the education allowance to another nurse in

the same department. That nurse had taken a postgraduate course in obstetrical nursing in Michigan, which included the same subjects and used the same textbook, although it was not described as a midwifery course. As the board concluded that the two courses substantially equivalent, it agreed the grievor was entitled to be paid the allowance.

A disturbing aspect of the award, the RNAO newsletter pointed out, was the board's finding that the grievor's possession of a midwifery part II certificate qualified her for the monthly bonus. The board rejected the association's contention that a part I certificate was evidence of sufficient obstetrical training, beyond the level Ontario nurses receive, to justify the bonus. "It would probably be difficult to persuade any future boards to reach a different conclusion," the newsletter added.

The newsletter stressed that the award does not advance the cause of those wishing to see midwifery become a legal nursing procedure in the province. "All it does is recognize the fact that training in midwifery... is useful to a nurse working in an obstetrical department.'

An RNAO task force is studying the possibility of legal recognition of

midwives.

#### Hollister° karaya seal appliances

By preventing skin excoriation and simplifying stoma care, Hollister's Karaya Seal appliances can help speed rehabilitation. Applying one promptly after surgery can prevent excoriation before it starts. The Karaya Ring fits snugly around the stoma, keeping irritating discharge away from the skin. Hollister appliances are disposable, one-plece units. Also available to the patient at authorized pharmacies nationwide. Write for free evaluation kit.

### help your ostomy patient achieve elf-care taster



World-Wide Hypertension Is Hidden Epidemic — WHO

Geneva, Switzerland — High blood pressure has become a world-wide problem, studies carried out by the World Health Organization show. In societies at all levels of affluence, roughly 10 percent of adults, both men and women, have blood pressure values above what is considered normal.

High blood pressure is largely an invisible disorder in the community, since only its direct complications are clinically apparent. Viewed in the light of its prevalence and its possible consequence, high blood pressure must be regarded as a widespread epidemic.

Systematic long-term treatment of hypertension has become possible since potent and relatively harmless drugs became available. As a result, pilot programs for the control of hypertension are being launched in 10 countrics, under WHO auspices. Altogether 750,000 people will be covered.

According to Dr. Thomas Strasser of the WHO cardiovascular diseases unit: "Hypertension is so frequent and so important a disorder that the general approach to its control must include, as in the case of any largescale epidemic, the management of whole communities as sociobiological entities in addition to the care of individuals.

For this purpose, both general practitioners and the public should be mobilized. Concerted action is. . . needed along three lines — the general health education of the public, the education of physicians, and the better care of hypertensives, including timely diagnosis and appropriate treatment.

The ultimate aim is a comprehensive program for the control of all cardiovascular disease, and perhaps other chronic diseases as well, in entire populations," concludes Dr. Strasser.

# One squeeze says it all.

Pick up any Davol syringe – 1 oz., 2 oz., 3 oz., 50 cc. or piston-type – and you'll notice the difference. It feels right. And works right. Because it's made right. With all the features of re-usables to make your job easier. Yet priced for single patient use. That's the Davol difference. The better way. Try one. Try them all. Ask your Davol dealer salesman for details.

Davol Inc., Providence, Rhode Island 02901. A Subsidiary of International Paper Company.



# new products



Talking exerciser for children

A new therapeutic exerciser that is fun and beneficial for children suffering from cerebral palsy, has been introduced by Overly Manufacturing Company.

The unit, called Peter Pachyderm, is designed to look like a stuffed toy. A soft, stain-resistant, plush elephant head with big floppy ears, short plastic tusks, and two huge feet below it is attached to the front of the exerciser. The elephant is tan and brown, with white tusks and toes. The tusks can be removed and reattached.

A tape recorder, fitted into a compartment behind the elephant's head, is activated by pushing a button in the tip of the trunk. The tape may have instructions, animal sounds, or a story on it and can be reached only by bending over. It provides an incentive for the child to perform exercises that may be painful.

The exerciser is suitable for children ages 3 to 14. It stretches and strengthens

the back, upper leg, and hamstring muscles. Feet and knee supports hold the heel lift down and help support the child's legs in a natural position.

The exerciser can be adapted to conform to the child's body size. Feet, knee, and abdominal supports are adjustable in one-inch increments. Legs may be positioned closely together or spread apart, depending on exercise requirements. Velcro fasteners on foot and knee supports provide a range of adjustments and make it easier to release the child. The waistband is secured by surcingle buckles.

This unit is mounted on a sturdy platform on four lockable easters, spaced so that it is impossible to tip the exerciser. Casters make the device easily transportable.

Additional information is available from Overly Manufacturing Company, West Otterman Street, Greensburg, Pa., U.S.A.

#### **ETIBL** tablets

ICN Canada has announced a new product on the Canadian market: ETIBI (Ethambutol HCI).

ETIBI is indicated in the treatment of all types of pulmonary tuberculosis. It is available in two strengths and colors: ETIBI 100 mg (peach) and ETIBI 400 mg (blue). Tablets are sold in bottles of 100 and in unit dose packaging.

The characteristic colors of the tablets are to help prevent confusion for patients taking Ethambutol tablets at the same time as other chemotherapeutic agents, such as Isoniazid.

Further information is available from ICN Canada Limited, 675 Montée de Liesse, Montréal 377, Québec.

#### Literature Available

Chemetron Corporation describes the use of suction equipment with piped vacuum systems in a new brochure for hospitals. This 12-page leaflet covers specific usage and installation in various locations throughout the hospital: operating rooms, recovery rooms, intensive care, emergency, labor and delivery, nursery, and patient rooms.

The leaflet goes into detail on the precise uses within these areas, covering aspiration, deep drainage, and pleural drainage. It also explains accessories to use in various applications. Illustrations throughout the booklet help explain procedures and show installations.

The leatlet (Form No. 104600-89) is available from Chemetron Corporation, Medical Products Division, 111 E. Wacker Drive, Chicago, Illinois 60610, U.S.A.

ICN Canada's 1973 Surgical Catalogue contains a complete range of surgical sponges, X-ray and non X-ray detectable, manufactured in Canada to specifications of operating room needs.

In addition, sponges will be manufactured to customers' individual requirements. Copies are available from Betty Meunier, Product Manager, Surgical Division, ICN Canada Limited, 675 Montée de Liesse, Montreal 377, Quebec.

for relief of postpartum discomforts

# only Tucks babies tender tissues two ways

as a soothing wipe...as a cooling compress...and as often as she likes

Tucks medicated pads give your postpartum patient more relief, more often than ointments or aerosols because pads can be used more ways. Cooling Tucks medication can be applied by using the pad as a compress. Or the pad can be used as a wipe to both soothe and cleanse. As a wipe, it lets her avold the mechanical irritation of harsh, dry toilet paper. A Tucks pad under her sanitary pad prevents chafing too.

Tucks medication gives prompt, temporary relief from postpartum discomforts—the itching, burning and irritation of episiotomies and simple hemorrhoids, Its active ingredients are witch hazel and glycerine—there is no "caine" type anesthetic

in it. Your patient can have her own supply of Tucks at bedside for self-administered relief with minimum risk of over-treatment or sensitization.

In addition, Tucks medication is buffered to an approximate pH of 4.6. This helps tissues maintain their normal acid defenses. Prescribe Tucks pads at bedside for soothing, cooling comfort from the first postpartum day on.

Order a trial supply on your Rx. Write to:

A Subsidiary of International Chemical & Nuclear Corporation 675 Montee de Liesse Montreal 377 Quebec



## **Double-Tex** Surgeons' Gloves

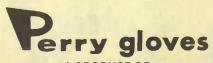


Need extra protection against slippage when you're handling slippery metal, glass and plastic surgical instruments? Try Perry's Double-Tex\* sterile, surgical gloves with light, velvet-textured palms.

You'll also get another exclusive Double-Tex feature. A special textured interior surface. Designed to protect against "in-the-glove slippage" caused by perspiration build-up during long procedures.

Double-Tex's strong, but thin, palm prevents binding. In addition, specially designed, curved fingers make Double-Tex a comfortable glove that is not fatiguing during long procedures.

Available in white and brown latex. Sizes 5½ through 9. Packaged in convenient peeldown, nonresealable outerwrap. Innerwrap provides a 276 square inch sterile field. Double-Tex. Just what you asked for and just from Perry.



AFFILIATED MEDICAL PRODUCTS LIMITED

90 Commercial Avenue, Ajax, Ontario

# Freedom: an outmoded tradition

In examining the concept of social freedom in education and professional organizations, the author explains why interdependence, not independence, is a central fact of social life. She criticizes professionals for retaining the status quo and calls professional organizations lackluster, bland, and conservative.

#### Joan M. Gilchrist, B.N., M.Sc.Appl.

The most avid supporter of the thesis that "I am captain of my soul and master of my fate" is finding this position increasingly difficult to support. This reflects an individualistic perspective of freedom, for it implies exemption or liberation from the control of others, lack of hindrance or restraint in choice of action, and not being required to conform. It is difficult to support because it is a traditional notion of freedom that does not fit a modern, urban, industrialized society.

A more tenable definition is one in which freedom is embedded in a social context. This is the concept of freedom I am using to argue for an educational, professional, and administrative revolution among the health professions and their organizations.

#### What is social freedom?

The traditional perspective of freedom suggests that creativity and individualization on the one hand, and conformity and participation on the other, are natural enemies. But much creative and productive work is performed by people who do a great deal of conforming. Similarly, self-affirmation does not denote an entirely free and separate individual, but is the affirmation of oneself as a partici-

The author adapted this article from a paper she presented in Montreal in October 1972 at a psychiatric nursing conference on freedom, sponsored by McGill University.

pant in the creative development of the system. This position we can call social freedom.

The following analysis dwells on ways in which individualization and participation, creativity and conformity, need one another for the existence of a social freedom. The validity of the concept "social freedom" depends on the assumption that individual personality is rarely, if ever, the sole determinant of behavior. Behavior always depends in some part on the situation in which the person finds herself at the moment.<sup>1</sup>

#### Social freedom and education

Have we attained social freedom in our educational institutions? If so, what are the outcomes? The major question in all our institutions is not how to acquire conforming behaviors, but how to generate creative ones. Our programs are designed to shape the individual to the requirements of a specialty or a profession. In fact, our training methods in the health professions in general, and in nursing in particular, process individuals to be-

The author is director of the school of nursing at McGill University in Montreal. As well as teaching at McGill, she has been director of nursing and principal of the school of nursing at the Jewish General Hospital in Montreal and has worked in two Toronto hospitals. She is completing work for a Ph.D. in sociology at McGill.

come more alike, speak the same language, share the same professional baggage, and engage in the same kind of activities in a prescribed way.

The common method of education is to transfer certain beliefs, attitudes, knowledge, and values from the mind of the teacher into the mind of the student. Thus it cannot properly be labeled education, for it does nothing to liberate or develop the individual because she is not free to think. This method simply relays what is known to the group being socialized and so breeds conformity without creativity. It is only a part of what an individual needs to practice her profession, and she surely has no social freedom to develop or nurture her creative potential

The creative person is, above all, highly developed. It appears possible to produce creative people or to raise the level of creativity in most people by educational means. Knowledge about how learning occurs can tell us when to provide structure and regime, when to be permissive, when to introduce particular ideas, and how to foster the imagination while teaching the person what she must know of reality.

True education is liberating and differentiating and, if successful, makes an individual different from every other. A program meeting these criteria nourishes the general powers and sensitivities; it creates social freedom

THE CANADIAN NURSE 25

for the individual and the real professional autonomy she seeks.

The first necessity for true education is providing situations for the learner to which she cannot adapt with the use of devices already present. Thus she is required to innovate, to generate new and suitable means of response. Presenting the learner with a succession of new challenges stimulates new responses. People must be challenged and jolted out of their complacency so they will revise their way of looking at things and be required to generate new perspectives and systems of response.

Dewey suggests that thinking as the method of educative experience makes individuals free within any structure, in the sense that each is free to make a choice among alternative courses of action. That is, she has the knowledge to make a rational, logical selection from known alternatives, each of which has predictable outcomes. Such knowledge allows the individual to participate freely. "Those who take part do not feel that they are bossed by an individual person or are being subjected to the will of some outside superior person. ... [they are] sharing in a common experience."2

Simply preaching the need to observe and identify the aspects of a situation, or to follow principles, falls short because these do not help the individual to understand the significance of what she sees, hears, and touches; nor do the so-called principles always fit. "This significance consists of the consequences that will result when what is seen is acted upon," says Dewey.<sup>3</sup>

Although some prior knowledge is essential, real learning must come from an experiential approach in which the applied knowledge is subjected to assessment and further refinement. This knowledge is then used to augment or change the original approach.

The features of this type of educational system must exist not only in the system that socializes people into a profession, but also in the environment in which they work and in which this creative potential must continually be developed. Only then will individuals be a viable force in a ward or institution and operate according to other forces that comprise the system.

#### Social freedom and organizations

If these are the ways in which our educational tenets have tended to promote rigidity and conformity to

dysfunctional systems of behavior, and if an educational revolution is needed to change this, then what of the effect on behavior of the organization as a structure? How can this structure be revolutionized to promote social freedom?

An administrative revolution requires adherence to some of the tenets of management to which I have alluded, and a reassessment of our ways of analyzing organizational behaviors.

The organization, with its rigid system of operant conditioning, can promote standardized, routinized behaviors. The extent of systematization to which the person is subjected tends to be associated with systematized individual behaviors. In any society there are pressures on the individual to conform with the group's ways. However, in most instances, says Sanford, the dissipation of the authority structure or lifting of repression would not by itself bring creativity or independence.4

In modern, highly industrialized society, there is a great deal of uniformity of behavior because people have to adapt themselves to the prevailing technology and social machinery. Homogeneity of behavior is not due to any widespread desire to conform, but to the fact that being different costs too much.

People differ in conforming behavior even in the same organization, culture, or society. Studies have shown the most creative people have the greatest flexibility of thinking, breadth of perspective, openness to experience, freedom of impulse, breadth of interest, integrity, and autonomy.

There is no validity to the notion that the organization alone produces conformity. We can cease to be so concerned about the so-called depersonalization associated with organizations and about their domination of the individual. Domination exists because people allow themselves to be dominated. Where there are continuously developing and knowledgeable individuals in an institution, there is usually a healthy institution, and vice versa.

Yet there is a certain determinism in organizational structure. The organization and its administrative system must change to allow the knowledge revolution to flourish and social freedom to prevail. What will happen in an administrative revolution?

Developments such as professionalization, specialization, and innovation are spelling doom for the bureaucratic mystique, if it ever existed. Berkley describes a new structural model, which is replacing the crumbling hierarchial pyramid, as a "loose, amorphous, sprawling affair" that is constantly changing.<sup>5</sup>

Management is multiheaded; its function is to coordinate and support, rather than exercise authority. Any model must reflect a change from perceiving organization as a rigid system of offices with allied roles connected by chains of command, which foster continuity, stability, unity, and subordination. Management can be seen as a system that permits continual testing and adoption of the untried and improves conditions to allow specialized knowledge and techniques to be more effectively used through rational behavior and planning procedures.

In this view, planning is a mechanism for stabilizing change and allowing for self-improvement. It requires the ideas, suggestions, interests, and experience of all who function within the system. Power is not a negative process to control freedom, but a creative, energizing force whereby interdependence, not independence, is a central fact of social life. These organizational and administrative features need to be accompanied by a reorientation of focus; the client's thinking and needs are the major factors determining behaviors.

It has been suggested that managers and administrators are taught the principles of behavioral science, not with the idea of sensitizing them to the needs of the people served, but to condition them to respond to the needs of the organization. The wanton and much publicized human relations approach in administration is merely a manipulative device, whereby concern with the individual's motivation, attitudes, and involvement in her work are used by management to solve organizational problems and make the individual satisfied with doing what she is told

The popular notion that this so-called individualistic approach to the worker — understanding her problems and so forth — leads to high morale, which in turn results in high productivity, is a myth. The outcome of this tends to be what management is seeking — conformity. Happy people are not neces-

sarily simply meeting the organization's goals.

Each individual's social freedom depends on factors within the institution and within the individual; obstacles to the development of the individual must be identified and removed. Even more important is the addition of elements that will generate creativity. Throw out all the rituals, even some of the new rituals like nursing care plans, which have merely replaced old rituals and which provide the staff with the fallacious notion they are "individualizing care." Instead, create a milieu in which experimentation is rewarded and thinking is encouraged.

There is hardly a clinical unit today in which all personnel are not primarily social slaves and organizationally-determined creatures of a system. They are cast in this role both by the educational system that prepared them and by the organizational and social environment of the work unit. Only knowledge of how to nurse without the organizational trappings of habit and routine can truly release the personnel from this position.

#### Social freedom and professionalism

The health professions, like all professions, have typically been perceived as monolithic. Many see their profession as having its own integrity, a mission separate from other disciplines, and so autonomous. But several perspectives of identity can be described in each profession; they originate largely through educational experience.

There may be as many differences of skill and opinion within each profession as there are among different professions. Each profession is far from homogeneous with respect to knowledge, social orientation, and capability of changing basic tenets. To speak of autonomy for a profession is to beg the question: autonomy of what for whom? Professional autonomy is elastic; it can be expanded or contracted, depending on judgments of competence. By what system is the judgment made?

In general, the professional is geared to retaining the status quo, avoiding situations, decisions, and regulations that will rock the boat. The outcome of professional competition and negotiation is typically to follow the majority in both individual behavior and in the stance of the organized profession. Most professionals reflect the prevailing

climate of opinion.

In short, professional organizations are lackluster, bland, and conservative, if not reactionary. Their paths of action seldom lead toward fertile grounds for development.

Moreover, a profession can be conceived as a social movement that builds the organization to forward its own aims, not those of the clientele. The days of a professional obtaining social freedom in the sense of determining what should be done, how it should be done, and whether it is being done properly, with no accountability to anyone but herself and her profession, are rapidly vanishing.

As Lynn has noted, "More than anything else, our professionals need to liberate themselves — just as their colonial predecessors did — from monopolistic notions of who should do what job and narrow-minded conceptions of their obligations to the community at large."6

#### **Toward solution**

In a revolution that has not been unduly destructive, radical, coercive, or uncompromising, we have made the first move to solve the educational problem. The development of the new college system provides an educational structure which, in affiliation with our health care agencies, can provide the type of education that produces social freedom. But structural change alone is insufficient. In these structures we require socially free, and thus knowledgeable, teachers who can stimulate thoughtful assessment of the outcomes of nursing acts and can use modern educational methods.

Adjustments in relation to the organizational and professional issues have been proposed in some areas and are being acted upon. In spite of the power of vested interests and research that has consistently been favorable to these interests and their agencies, the proposals cannot be labeled timid reformism. New Professions Acts should place the operation of professionals in a context more appropriate to our changing values, that is, in the hands of representatives of all segments of the population.

The objective is for all of us to have social freedom and control so that no one needs to protect it, or fight for it, or value it. The fine lines of custom and law will no longer demarcate the health professions along rigid functional lines. Each professional will be

accountable primarily to the client she serves. This eauses concern only among the professionals themselves, for many of us are ill-prepared to select and develop our roles in a system with few guidelines.

Organizational walls are being perforated but must disappear as the large multisystemed hospital complex becomes dispersed and moves, in some cases, closer to the people it serves. Client and professionally initiated health clinics will allow us to preserve health, treat illness, and maintain life in a truly comprehensive system, with professionals east in new roles.

We are now actualizing some of what we have discovered in the past. Much more remains to be discovered about making these systems work. Our success will depend on our ability and our inclination to direct a barrage of criticism toward our institutions and so reduce the essential "unfreedom" of our society.

#### References

- Sanford, Nevitt. Self and Society: Social Change and Individual Development, New York, Atherton Press, 1966, p. 203-5.
- Dewey, John. Experience and Education, New York, MacMillan, 1944, p.57.
- 3. Ibid., p.79.
- 4. Sanford, op. cit., p. 210.
- 5. Berkley, George E. The Administrative Revolution: Notes on the Passing of Organization Man, Englewood Cliffs, N.J., Prentice-Hall, 1971, p.25.
- 6. Lynn, Kenneth S., ed, and the editors of *Daedalus*. *The Professions In America*, Boston, Beacon Press, 1963, p.13.

# Changing nursing practice through education

This report of McMaster University's program to prepare family practice nurses shows that changes in patterns of practice can be made through the educational process.

D.J. Kergin, R.N., Ph.D.; M.A. Yoshida, R.N., M.N.; W.O. Spitzer, M.D., M.P.H.; J.E. Davis, R.N., B.Sc.N.; and E.M. Buzzell, R.N., M.N., M.Ed.

Probably no other major "industry" in Canada has been subjected to as much scrutiny as our health care system. Nationally, we have seen the reports of the Royal Commission on Health Services, the Task Forces on the Costs of Health Services, and, more recently, the Community Health Centre project. This Community Health project places major emphasis on providing health services through a team of health professionals and other personnel, working as partners with members of the community.<sup>1</sup>

Of particular significance to nursing is the Report of the Committee on Nurse Practitioners.<sup>2</sup> This Report stresses the importance of the multidisciplinary team and views changes in the nurse's role as being fundamentally linked to changes in the team.

Over the years, the cost of health care in Canada has been increasing, and important groups among both consumers and professional health workers have expressed dissatisfaction with some aspects of the way care is provided.<sup>3</sup> Although there will undoubtedly be limits on expansion in terms

of available resources, the rate of change will accelerate to make the system more effective and responsive to the needs of Canadians.

Focusing on the McMaster educational program that prepares family practice nurses (nurse practitioners), we will attempt to show that changes in patterns of practice can be effected through the educational process. Conversely, we hope it will be apparent that evaluation of an educational program cannot be fully accomplished without assessing changes that occur subsequently in the practice setting.

#### McMaster's program

The aim of the educational program, sponsored jointly by the faculties of medicine and nursing, is to prepare nurses who can assume responsibility for specific aspects of primary care, working with physicians and other health workers in ambulatory settings, primarily family practices.

In 1971, an initial pilot program

Grants supporting work reported in this paper are gratefully acknowledged by the authors. These grants include: Ontario Health Resources Development Plan, Demonstration Model Grant DM36; National Health Grants, Department of National Health and Welfare, NHG 606-21-48, NHG 606-22-34, NHG 606-22-35; and grant from Ont. Medical Foundation.

was completed by 22 nurses.<sup>4,5</sup>. This program was of a work-study nature; that is, while the nurses were enrolled in the program, they were concurrently employed in physicians' offices. The schedule included one-half day to a full day of planned educational activity per week, and one full month on campus. The rest of the nurses' time was spent in the offices in which they practiced their developing skills, under the guidance of the associated physicians. By means of several related studies, known as the McMaster Collaborative Studies of the Nurse Practitioner, we are currently evaluating the pilot program and monitoring its effect on the practice settings.

After assessing the objectives and curriculum of the pilot program, we initiated, in the fall of 1972, a revised educational program that was to be repeated every six months over a threeyear period.<sup>6</sup> The new program consists of four months of study and practice on campus, followed by a four-month "internship," during which McMaster faculty provide periodic supervision. Because we are recruiting nurses from medically underserviced areas at some distance from Hamilton, the alternating work-study type of program is no longer feasible. If a number of nurses apply from geographically convenient areas, this plan may be resumed periodically, in response to demand.

Role change cannot occur in isola-

The nurse authors are on the Faculty of the School of Nursing, McMaster University, Hamilton, Ontario, Dr. Spitzer is with the Department of Clinical Epidemiology and Biostatistics, Faculty of Medicine, at the same university.

28 THE CANADIAN NURSE

tion. A fundamental prerequisite for any change in role is modification of the expectations that others may have for the role incumbent. As well, others may need to change their responsibilities and activities. For this reason, we recognize the need to have physicians, with whom the nurses work, participate in the educational program so each will develop an appreciation of the full range of abilities of the nurse practitioner and the functions that could be performed by and delegated to her.

As well as requiring that the physicians schedule time for teaching at the home base, at least one afternoon session per month is planned to involve both nurses and physicians. Agreement by a physician-associate to participate in the program and to permit access to the practice by Mc-Master faculty remain essential requirements if a nurse is to be admitted to the program.

Two major factors continue to affect the willingness of physicians to sponsor a nurse's application to participate in the educational program and to commit themselves to subsequent functional changes in their practices. These are:

- 1. Financial arrangements (fee for service) that do not permit a practice to receive income for services rendered by a person other than a physician, and are not supervised by a physician. Neither is there provision for reimbursement to a practice for salary and overhead costs incurred through the employment of allied health professionals.
- 2. Uncertainty regarding the legal status of professionals who are associated with physicians and who assume clinical, decision-making responsibilities.

Both the pilot and the continuing program are directed toward the acquisition or refinement of specific skills and abilities on the part of the nurse. In brief, these are:

Techniques involved in: interviewing and history taking; physical ex-



amination; pre- and postnatal care; and well-child care.

Evaluation and management of: common acute and chronic disorders; common emotional disorders; common disorders of family functioning; and problems of the elderly.

The graduates of the program acquire the ability to make correct decisions about primary-care patients. The more frequent alternatives are: recommendation of specific treatment; no intervention other than support, reassurance, or education; and referral to the physician, another health-related professional, or to a community agency.

Our target population groups are those that require ambulatory or primary-care services and live in settings in which medical support is generally available. That is, we are not preparing nurses for remote northern outposts where there are no physicians within a reasonable and convenient travel distance.

Throughout the program, emphasis is placed on knowing what is "normal" physically and emotionally and on identifying and describing deviations from the normal. The intent is not to prepare nurses who presume to be diagnosticians; rather, it is to develop in them a high level of suspicion and the ability to recognize findings that lie outside the normal range or that may require intervention by themselves or by their physician colleagues.

Two principal features of the teaching-learning strategy for the program are:

I. A problem-oriented consideration of clinical situations that have relevancy for the nurses and their practice settings within the objectives of the program.

2. A clear recognition that learning is an individual matter, occurring at different rates, and is best achieved in an environment that stimulates self-learning and the setting and attainment of individual goals.

The small group discussion serves as the primary method for developing problem-solving ability. Extensive use is made of McMaster's audiovisual and library holdings and human resources (both faculty and students) to extend the students' skills and knowledge and to help them achieve individual goals. Concurrent clinical practice provides for application, refinement, and extension of skills and knowledge.

Through interviews with the 22 nurses who graduated from the pilot program, two to three months after they completed it, general impressions were gained of the changes their involvement in the educational program had made in their activities.

The application of program objectives in the practices was influenced by the characteristics of the practice population and by the preferences of the nurses and the physicians. The nurses were functioning as primarycontact health professionals for a variety of patients and families. Clinical activities were mainly concentrated on pre- and postnatal care and on services for well children, along with assessment and management of common acute and chronic health problems experienced by individuals of all ages. After completing the appropriate history and physical assessment, the nurses would either provide the required care, consult with the physician, or refer the patient to him.

As well as assuming the challenge of increased responsibilities for assessment and management of health complaints, the nurses found the increased contact with patients rewarding. More professional time was available in the practices for health teaching and anticipatory guidance. This subsequently resulted in a better understanding of the patient as a person and as a member of his family and community.

#### Changes in practice

We are now completing studies to assess the effect that the pilot nurse practitioner educational program has had on the practices involved in the program. In total, 16 family medical practices have been participants in the studies, which are reported in detail elsewhere. 7.8 In addition, baseline

data on nurse activities and on patient, nurse, and physician perceptions of health care activities are described in a separate report that also includes samples of instruments used in all the studies to assess nurse activities, <sup>9</sup>

**Burlington Trial** 

In two practices, after the nurses had completed the pilot educational program, the patients were randomly assigned to either the physician or the nurse for their first and continuing care. The study was designed to focus on the effects on patients and on economic aspects. Neither of the practices was affiliated with a university or a hospital.

Before the start of the trial, the health status of the patient was determined by household surveys of a random sample of both groups. Both groups were similar in four major indexes, which were: physical function on the day of the interview and for 14 days before the interview; performance of usual daily activities; bed disability; and satisfaction with care received. These same variables are now being reassessed to determine whether the equivalent status has been maintained, and initial review of data suggests there are no significant differences between the groups.

Preliminary data show that implementation of the changes in the practices progressively affected the physician's involvement in patient visits. Before the trial began, physicians were involved in 86 percent of all patient visits; in the first two months of the project, physicians were involved in 45 percent of patient visits to the nurses; from the fourth and fifth months forward, this percentage dropped further to approximately 35 percent and has been maintained at that level throughout the trial.

The reduced level of physician involvement may explain another key finding: the practices, previously saturated, were able to add 20 percent more families to their roster during the year of the trial. They continued to accept new families for at least

**APRIL 1973** 

nine months after the conclusion of this Burlington trial.

Southern Ontario Trial

This trial took place in 14 practices located within 50 miles of Hamilton. All 14 office nurses had applied to the pilot nurse practitioner educational program. By random assignment, 7 applicants were enrolled in this program and then rejoined their physician colleagues as the experimental group. The other 7 nurses continued in traditional roles, and these practices became the controls.

Two of the practice groups later dropped out: an experimental one, which had professional and financial dissatisfactions, and one of the controls, because it became affiliated with a university. Thus, at the end of the first year, each group contained six prac-

In brief, the findings show that diagnosis and management with the patient present occupied 56 percent of the experimental group nurses' time, in contrast to 33 percent for the control group. For diagnosis and management by telephone, the comparative values were 10 percent and 4 percent. Clerical and housekeeping tasks took nearly twice as much of the conventional nurses' time (39 percent) as of the experimental group nurses' time (20 percent).

Similar time and motion studies of physicians showed no differences between the experimental and the control groups. In both groups of physicians and nurses, job satisfaction scores were high; differences between the experimental and the control groups were small, except for remuneration.

The experimental group of nurses, whose salaries were higher, were particularly satisfied with their income. The physicians in the experimental group were much less satisfied with the finances of the new arrangement, probably because no charge can yet be made for unsupervised services provided by a nurse. In spite of these views on finances, the physicians and nurses in the experimental group were satisfied enough to retain this new approach after the formal study period ended.

Assuming that satisfactory health status is maintained in patients and families receiving services primarily from the nurse, we can already conclude

 Compared with conventional nurses, family-practice nurse graduates spend about 50 percent more time in clinical activities and 50 percent less time in clerical/housekeeping duties. Moreover, a larger proportion of the nurse's clinical activity time is spent in health teaching and counseling activities.

☐ With the passage of time, family nurse practitioners' patients require progressively less attention from the physicians.

Practices that were previously saturated have grown substantially.

The provision of primary care by family nurse practitioners in Southern Ontario is satisfactory to nurses, to physicians, and to patients. Furthermore, through data elicited from patients and further studies assessing standards of practice, we hope to conclude that the quality of this care has been enhanced, with no increased cost to the Canadian economy.

#### Conclusion

A climate of trust and freedom to experiment are essential ingredients if one wishes to achieve changes in practice through educational programs. This climate must pervade educational and practice settings, and is as important in initial nursing educational programs as it is in programs of a continuing educational nature, such as the family practice nurse program. Experience gained through educational and research programs, such as we have reported, should provide guidelines for the modification of basic educational programs in the health field, particularly those offered in university health sciences centers where interprofessional collaboration is more readily achieved.

A number of nurses and physicians emerging from educational programs

today will be the practice innovators of tomorrow. Their enthusiasm and capacity for change must be capitalized on to determine the practice patterns of tomorrow.

#### References

- 1. Report of the Community Health Centre Project to the Conference of Health Ministers, Canad. Med. Ass. J. 107: 4:361-80, Aug. 19, 1972.
- 2. Canada. Department of National Health and Welfare. Committee on Nurse Practitioners. Report. Ottawa, Dept. of National Health and Welfare, 1972.
- 3. Canada. Parliament. Senate. Special Committee on Poverty. Poverty in Canada; Report. Ottawa, Information Canada, 1971.
- 4. Kergin, Dorothy J. and Spitzer, W.O. An educational program for nurse practitioners; report on a demonstration project. Hamilton, Ontario, Division of Health Sciences, McMaster University, 1972. (Ontario Health Resources Development Plan, DM36.;
- 5. Spitzer, W.O. and Kergin, D.J. Nurse practitioners in primary care: 1. The McMaster University Educational Program. Canad. Med. Ass. J. (In
- 6. A university educational programme for family practice nurses. Canada Department of National Health and Welfare, National Health Grant (NGH 606-22-35), 1972-75. (Study in progress.)
- 7. Spitzer, W.O. et al. Financial consequences of employing a nurse practitioner. Ont. Med. Rev. (In press)
- 8. Spitzer, W.O. et al. Nurse practitioners in primary care: III. The Southern Ontario randomized trial, Canad. Med. Ass. J. (In press)
- 9. Kergin, Dorothy J., Yoshida, May A., and Tidey, Mary H. A study of nurse activities in primary care settings. Hamilton, Ontario, McMaster University, School of Nursing, 1972.

# A new method of tubal ligation

The perfect contraceptive is still to be discovered. But for the husband and wife that have decided their family is complete or for the woman that lives in terror of another pregnancy, tubal ligation using the laparascope is the best solution at the present time.

#### **Beverley McBride**

The woman sat opposite me in our family planning clinic, nervously jabbing her wedding band off and on her finger. My reaction was one of surprise when she told me she was 32. Her face and bearing, mirroring endless days of hard work and worry, made her appear 40. "I want to have my tubes tied," she murmured and then quickly and tersely added, "I suppose you're going to say no, too." Refused the operation by two other clinics, she was justifiably fearful of our answer.

As she told me the story of her husband's accident, she jerked her ring convulsively round and round her finger. It happened while he was working on a construction job. His backbones were now "permanently stuck together," she explained, and he could no longer work at the only trade he knew. Apparently no one is hiring disabled bricklayers.

Ms. Porter now works evenings as a waitress to keep her three school-age children and her husband off the welfare rolls. After putting in a full day at home, it is tough work. Mr. Porter, who is not adjusting to this reversal in marital roles and angry because he cannot get work, is irritable.

Ms. Porter is worried about her added responsibilities and perpetually terrified of getting pregnant; she is little consolation to her husband.

We talked for awhile; as the conversation progressed, she began to relax. We discussed the finality of tubal ligation. Despite articles she might have read in magazines, we do not consider the procedure reversible. That was the least of Ms. Porter's worries; her concern was whether it was 100 percent effective! I explained that we didn't hand out written guarantees with each tubal ligation, but the operation is as close to 100 percent as anything can be.

I asked her how she and her husband would feel if any of their children died. They had given this every serious consideration and decided that, if anything did happen, no other child would take the place of one that had been lost. Anyway their financial situation, barring a sweepstake winning, just did not allow for any more children. It was evident to me, as we sat and talked, that this couple had given their decision the important deliberation it should have.

Although the final decision rested with her doctor, I was able to put Ms. Porter's mind somewhat at rest by telling her I was sure the hospital would be agreeable to her having a tubal ligation. Unlike many other clinics that operate by the "rule of 120" (you

Ms. McBride, who graduated from the Montreal General Hospital school of nursing in 1958, is instructor in the family planning clinic at the same hospital.

multiply the patient's age by her number of children and it must come to 120 or more, regardless of any personal situation), we evaluate each case and decide on its merits, whether the patient's statistics equal 120 or not.

The fingers that had been frantically twirling the ring began to ease. Ms. Porter and I discussed her two-day stay in the hospital. She was worried that she might have to remain longer and risk losing her job. We finally came to an agreement. She would ask her boss for two days off, then add her regular two days off to it for recuperation at home. Recovery after a tubal ligation by laparoscopy is speedy.

Visibly more relaxed, she wanted to know how the operation was done. I explained the entire procedure, including the surgery, in simple terms.

Ms. Porter would come into the hospital the night before for a complete physical examination and a good night's rest. In the morning, before the operation, she would be given medication to make her drowsy and relaxed. Then, a short while later, there would be a trip in the elevator down to the operating room. Once the words "operating room" were openly expressed, she looked concerned and stated she was terrified she would be awake during the operation. Apparently a friend of hers had been fully conscious for her abortion and found the experience unnerving. I assured Ms. Porter she would definitely be asleep.

#### Procedure

A general anesthetic is used for this operation because of the effects of a large amount of gas present under the diaphragm and the moderately steep Trendelenburg position necessary. Once the patient is fully anesthetized, a needle is passed through the abdominal wall into the peritoneum and then attached to a gas machine. The peritoneal cavity is insufflated with approximately three liters of carbon dioxide. This gas is used because it does not support combustion, is not explosive, is rapidly absorbed, and is excreted through the lungs.

A small incision is made just below the umbilicus and a trocar passed through into the peritoneal cavity. The trocar is removed from the sleeve and replaced with a laparoscope. The laparoscope is, simply, a telescope with a special cold light (fiberoptic light) attached to it. Since the light is not hot, as light usually is, it can be used in the abdomen for longer periods with complete safety. Looking through the laparoscope, the doctor can visualize the abdominal organs and, more specifically, the fallopian tubes.

Another small incision is made in the side of the abdomen (each gynecological surgeon has his preferred location for the second incision), and the cauterizing instrument is passed through. Looking through the laparoscope, the surgeon guides the cauterizing instrument to the tubes and applies it. The tubes are burned and cut with a cautery that has both burning and cutting currents. Once the procedure is finished, the abdomen is deflated; the cautery and laparoscope removed; the umbilical incision closed with two absorbable sutures and the abdominal incision closed with one. Application of two small Band-Aids, one to each incision, completes the entire procedure that lasts less than 30 minutes on an aver-

Ms. Porter was warned that she would wake up in the recovery room, return shortly after to her own room, then probably be discharged from the hospital the next morning. After talking with me, Ms. Porter had a gynecological examination done by her doctor, who also took her medical, menstrual, and family history.

A happier, more relaxed Ms. Porter came to see me after her examination and said her name was now entered on the hospital's operating list. She was a little disappointed when I told her it would take six to eight weeks before the hospital would call her in. She expected to be admitted right away. We discussed a method of contraception to use during the waiting period. She had bad varicose veins in her legs and could not take the pill, so she decided

that foam and condoms would be their choice of birth control until her operation.

Ms. Porter was naturally inquisitive about any side effects she might have from the operation. I explained there might be some pain under the diaphragm referred to her shoulder and this was due to the gas put into her abdomen. This would only last for a few days. Incisional pain would be minimal because of the smallness of the cuts made.

When I asked Ms. Porter if she had any other questions, she looked rather embarrassed and said she had one. A friend had told her that her periods would stop after she had her operation and she wanted to know if this were true. We discussed the menopause and hysterectomy and the difference between them and a tubal ligation. I asked her to pass the information on to her friend. Ms. Porter left our clinic assured of her operation, a short stay in the hospital, and hope for a solution to some of her problems.

Advantages of laparoscopy are apparent. Women who previously could not afford six to eight days in the hospital and a long recuperation period at home can now have a tubal ligation and be back at work or in the home fully recovered in two or three days. Although vasectomy is faster and easier than laparoscopy, there is still great male reluctance to the operation, so female tubal ligation with laparoscope is a good alternative.

The perfect contraceptive is still to be discovered. But for the couple that has decided its family is complete or for the woman that lives in terror of another pregnancy, tubal ligation using the laparoscope may be the best solution at present.

#### Bibliography

Siegler, Alvin M. Trends in Laparoscopy, Amer. J. Obstet. Gynec. 109:5:794-809, 1971.

# Laparoscopy

For the past five or six years, the laparoscope has had wide use by gynecologists and surgeons in investigation and treatment. At present, the laparascope is used primarily for permanent sterilization of women.

Peter J. Beardall, MB., ChB., M.R.C.O.G., F.R.C.S.(C)

Laparoscopy (peritoneoscopy, or celioscopy) is endoscopic visualization of the peritoneal eavity through the anterior abdominal wall, after the establishment of a pneumoperitoneum. This method of intraperitoneal examination has been known since the turn of the century and was first tried on human beings in 1910 by Jacobaeus.

The simple cystoscope was the first instrument used in visualizing the abdominal cavity, but it was the development of a cold, fiberoptic light source that allowed for prolonged examination and visualization of the abdominal cavity. After this, refinements were made to the laparoscope itself and, for the past five or six years, the instrument has had widespread use by gynecologists and surgeons in investigation and treatment.

When the instrument became widely used and available five years ago, gynecologists believed its main contribution would be made in investigation and diagnosis of gynecological conditions. At present, the laparoscope is most widely used for permanent sterilization.

The instruments necessary for laparoscopy include the laparoscope, which may have a lens set at 180 degrees or at 135 degrees from the vertical, a pressure flow control system for carbon dioxide gas, a fiberoptic

light, and an introducing trocar and cannula for the laparoscope itself. Some surgeons use a Verres needle for producing the pneumoperitoneum.

The laparoscope comes with an ovarian biopsy forceps and an instrument for tubal coagulation and biopsy.

#### Anesthesia

Anesthesia for laparoscopy normally includes intubation, ventilation, and the use of muscle relaxants. The patients are intubated and ventilated to maintain adequate respiration at all times, despite changes in position and increased intra-abdominal pressure. Ventilation should be adequate to maintain normal levels of carbon dioxide in the blood, despite the

Dr. Beardall is a South African medical graduate who took postgraduate training in obstetrics and gynecology at the Royal Victoria Hospital, Montreal, and in Britain. He practices obstetrics and gynecology in Ottawa. The author acknowledges the help, in preparing this paper, given by Mary Armstrong. supervisor, and Diane Urquhart, head nurse, operating room, Ottawa Civic Hospital. He also thanks Dr. R.W. McIntyre, department of anesthesiology, Ottawa Civic Hospital, for advice on anesthesia in laparoscopy.

absorption of earbon dioxide from the abdominal cavity. Intra-abdominal pressure may be reduced by the use of relaxants.

#### **Procedure**

The patient is anesthetized and placed in a lithotomy position with the leg stirrups at a forward angle of 10 to 15 degrees to allow the operator more room while using the laparoscope and working on the abdomen. The patient is prepared by using a Betadine solution from the nipple to the knee, including the vulva and vagina. She is draped in the same way as for an abdominal perineal operation.

The various connecting tubing and cables are made secure from the draping to the respective machines, such as the fiberoptic source, the Bovey electrocoagulator, and the carbon dioxide gas source.

#### Operative technique

The operator approaches the patient from the perineal side and performs an examination under anesthetic, having first emptied the patient's bladder by catheter. From the operative point of view, the most important thing to note is whether the uterus is retroverted or anteverted.

Having ascertained the situation in the pelvis, a rotunda bivalve speculum

**APRIL 1973** 

is inserted into the vagina and the cervix is visualized. The anterior cervical lip is grasped with a singletoothed tenaculum and pulled slightly downward. The Rubens cannula is inserted gently into the endocervical canal and made secure to the tenaculum by means of the Y clamps provided.

After the operator regowns and is given new gloves, he approaches the patient from the left side. During anesthesia induction, the arm board should be placed on the patient's right side so the surgeon may have free access to the left side of the patient's abdomen. Two methods may be used to obtain a pneumoperitoneum: carbon dioxide or nitrogen. Carbon dioxide is the gas preferred.

A one-half inch semilunar incision is made in the umbilicus, just big enough for the introduction of the laparoscope, trocar, and cannula. If this incision is too large, gas will leak around the sides of it and insufficient pneumoperitoneum will be obtained. With the patient well relaxed, the anterior abdominal wall is grasped with the left hand and raised toward the ceiling as far as possible. With the laparoscope, trocar, and cannula firmly in the right hand, the sharp end is introduced through the incision made in the umbilicus and forcibly pushed into the abdominal cavity in a direction toward the uterus for three or four inches. The carbon dioxide source is attached to the cannula and switched

A pneumoperitoneum is produced with carbon dioxide, using between four and seven liters of the gas. At all stages of the induction of pneumoperitoneum, it is important that the pressure of gas flow into the intraperitoneal cavity does not rise above 20 mm. of mercury. Should this occur, it often indicates that the instrument is not in the right cavity or that the outflow of gas is up against some solid object, raising the pressure.

An alternative method is to use a Verres needle to secure the pneumoperitoneum. In this case a smaller incision is made in the umbilicus and the Verres needle is inserted into the abdominal cavity in the direction of the uterus. To make sure of the intraabdominal position of the tip of the Verres needle, the uterine fundus is touched with it transabdominally; by so moving the fundus, it is possible to move the instruments attached to the cervix through the vagina.

After the pneumoperitoneum is produced, the laparoscope is introduced through the cannula and connected to its light source. The moment of truth has come when the operator puts his eye to the eyepiece of the laparoscope and views the abdominal cavity. If good pneumoperitoneum has occurred, visualization of small bowel, large bowel and the pelvic contents is easy and impressive. Sometimes it is necessary to place the patient slightly in the Trendclenburg position to allow the small bowel to fall away. Also, the operator may have to manipulate the instruments protruding from the vagina to antevert the uterus or to move it about to shake omentum or loosely adherent small bowel from it.

Carbon dioxide gas continues to be passed into the abdomen since it is absorbed at a rate of approximately 200 cc. per minute. If a constant supply of gas is not present, the operator is unable to make out the abdominal contents. By moving the intravaginal cannula to the left or right side, the ovaries on either side can be visualized; by injecting dye into the cannula, the patency of each tube is readily observed.

The operating room lights are turned down and the anterior abdominal wall is transilluminated, using the fiberoptic source and laparoscope, to delineate markings on the anterior abdominal wall, especially the course of the inferior epigastric artery. At

about McBurney's point on the left side, a small incision of one-eighth inch (3 mm.) is made, and a small trocar and cannula introduced into the pelvic cavity. The operating or biopsy attachment of the instrument is introduced through this cannula and connected with the Bovey electrocoagulating machine. With the forceps attached to this instrument, it is possible to lift up objects in the abdominal cavity and to examine them more closely through the laparoscope.

For sterilization, each tube is grasped by the instrument midway between either end and electrocoagulation is performed, using the Bovey setting at 50. The tube during this procedure is observed to blanch visibly; the blanching extends for approximately one-quarter inch on either side of the grasped portion of the tube. Almost the whole length of the tube may be blanched and cauterized in this way. The operator may or may not remove a segment of the tube, using the cutting attachment of the operating instrument. Occasionally sparks and smoke may be seen in the abdominal eavity, arising from the tubes that have just been coagulated. The ovaries or other intraabdominal tissue may be biopsied.

By swinging the laparoscope so that its tip points upward to the patient's head, it is possible to visualize the liver, the gall bladder, and, in some cases, the stomach. Good abdominal distension, as produced by pneumo-

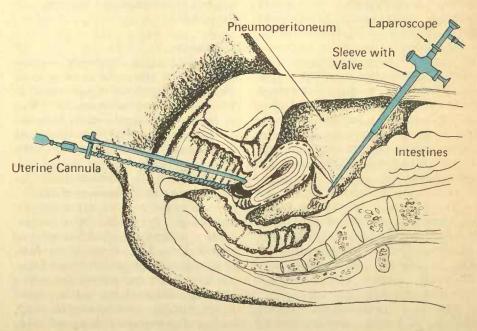


Diagram showing gynecologic laparoscopy.

peritoneum, is necessary all the time.

When the operation is completed, the laparoscope is removed from its cannula, keeping the trumpet valve of the cannula open, and carbon dioxide is allowed to escape from the abdominal cavity and so reduce the abdomen to its normal size and shape. The operating trocar and cannula are removed and the wounds are closed with Michel clips and covered with Band-Aids. The patient in returned to the recovery room and is usually able to be up and about within one or two hours; she may then be discharged from the hospital. In an efficient institution with a well-organized team, the total procedure from beginning to the end of anesthesia should take between 30 and 45 minutes at most.

#### Indications and contraindications

The indications for laparoscopy in gynecology and obstetrics have fairly wide limits. The principal indications include; permanent sterilization; infertility due to tubal occlusion or peritoneal adhesions; amenorrhea, primary or secondary, with ovarian biopsy; suspected ectopic pregnancy; unexplained chronic pelvic pain, including dysmenorrhea; obscure pelvic masses; verification of suspected pelvic inflammatory disease; acute pelvic pain of uncertain origin; and verification of metastatic liver disease.

The procedure may also be used for the following: differential diagnosis of ascites; staging of carcinoma of the cervix, endometrium, and ovary; accurate measurement of radiation dose; removal of displaced uterine contraceptive devices; evaluation of treatment of endometriosis; postcoital examination of fluid in the cul-de-sac for sperm; bacteriologic and cytologic examination of fluid in the cul-de-sac; ventral suspension of the uterus; aspiration of ovarian cysts; studies of tubal physiology: and studies of ovary before and after drug stimulation.

The contraindications for the use of this technique are: severe cardiac or respiratory disease, except where local anesthesia can be used; diaphragmatic hernia; abdominal, umbilical, or inguinal hernia; and acute distended surgical abdomen with intestinal obstructions.

Relative contraindications are: previous laparotomy, except where the operation was an appendectomy done by a McBurney incision; ascites; obesity; and diffuse intra-abdominal malignancy with ascites.

#### Complications

A setup for abdominal laparotomy should always be on standby in the operating room where laparoscopy is being performed.

Most complications occur while establishing the pneumoperitoneum. These include: hemorrhage from puncture of abdominal vessels; gas embolism; intestinal perforation; subcutaneous emphysema; and respiratory or circulatory embarrassment. Proper technique and proper selection of cases can avoid most of these complications. An empty bladder is important.

Other reported complications include: perforation of a vessel or viscus with the large trocar; herniation of intestine into or through the incision, if the patient strains before closure; and bleeding from the tenaculum site on the cervix, after the instrument has been removed.

It is easy to cause burn damage to intra-abdominal contents, by inadvertently touching the coagulator pedal of the Bovey machine. For this reason, the Bovey machine should be turned on when it is about to be put to use and turned off immediately after. Some surgeons prefer asking the anesthetist to depress the pedal of the Bovey coagulator when necessary, which removes the risk of the surgeon inadvertently stepping on the pedal.

#### Discussion

Laparoscopy is becoming increasingly popular and useful as a diagnostic and therapeutic tool. It has proved to be a safe, simple procedure with numerous advantages over its predecessor, culdoscopy. For one thing, the culdoscope cannot be used when there is evident disease in the culde-sac, such as endometriosis or chronic pelvic inflammatory disease.

Even in the most expert hands, the discomfort experienced by some patients undergoing culdoscopy is considerable. This is one of the most important advantages of laparoscopy, particularly in the patient for whom an examination of the pelvic organs is more or less an elective procedure, such as the woman with an infertility problem.

There can be no question that being able to avoid such a major procedure as exploratory laparotomy just to make a diagnosis is desirable. The instrument will significantly alter the management of a certain percentage of patients. If the laparoscope is used for confirmation of suspected diagnosis, it will not greatly change the anticipated management of these patients. It will, however, enable those responsible to proceed along the planned course with greater assurance of correctness.

It has changed sterilization from a three- or four-day inpatient hospital stay, including a laparotomy, to a recovery room procedure in which the patient is admitted and discharged on one day. From a nursing point of view, the situation is simply one of caring for a recovery room patient with early or immediate ambulation.

Laparoscopy instruments and equipment are expensive and delicate; they should be handled and treated with great care. All parts of the instruments should be taken apart after operation, washed, rinsed, dried, and lubricated as necessary. Improper assembly damages the instruments and is an incomvenience and hazard to the patient.

Detailed and continuous inservice education is necessary for OR nursing staff working with the laparoscope instruments and equipment. If possible, this inservice education should be on an individual basis, with one person doing the teaching. All the equipment, sterile laparoscope instruments and cords, the CO<sup>2</sup> source, and lights should be kept on a portable cart. All the equipment for cleaning and lubricating instruments are also kept on this cart.

#### **Bibliography**

Fear, Robert E. Laparoscopy: a valuable aid in gynecologic diagnosis. *Oshtet*. *Gynec*. 31:3:298, Mar. 1968.

Steptoc, P.C. Laparoscopy in gynae-cology. London, Livingstone, 1967.

# Weekend program for tubal ligation

Pre- and postoperative home visits by a VON nurse and coordinated hospital care for a group of six women are features of a weekend program for patients having tubal ligation. Patients appreciate being in hospital only on the weekend, when their husbands are home to care for their children, and feel special when they receive individual attention.

#### lanie Gardner

Sterilization by tubal ligation is no longer reserved for women whose health will not permit further pregnancies. Neither is it permitted only for women over a certain age with a certain number of children. Within the last few years, thousands of women in Canada have sought and obtained tubal ligation for permanent contraception.

At the Grace General Hospital in Winnipeg, the increased number of women seeking a tubal ligation, combined with a shortage of beds for shortterm gynecological patients, meant a lengthy waiting period for the women wishing this surgery. Medical and nursing personnel at the Grace Hospital, concerned with the care of these patients, explored several alternatives.

#### A community-oriented program

In the autumn of 1969, the staff adopted a new way to provide service, which they believed would increase the number of patients able to have surgery, would minimize the patient's hospital stay, and would meet the special emotional needs of the patient undergoing a tubal ligation. The hospital administrator applied for a grant from the Manitoba Health Services Commission for the new program. When it was approved by the Commission, the Grace Hospital approached the Winnipeg branch of the Victorian Order of Nurses for its support in supplying a nurse to provide the home nursing care involved.

In January 1970, a special weekend program for patients having a tubal ligation began at the Grace Hospital. After evaluation, some minor revisions were made; under the program today, six patients are slated for surgery each Friday morning and early Friday afternoon. On Thursday, the VON nurse prepares all six women at home.

Two weeks prior to surgery, each patient receives a letter from the hospital. This letter explains the nurse's intended visit and also gives the patient information to help her prepare for hospitalization.

All patients report two hours prior to surgery. An RN employed for the program cares for them as a group in a specially prepared room on the gynecological floor. Patients are premedicated in this room and sent to the OR.

If the bed situation permits, all six patients return to the gynecological floor. They are discharged Sunday at noon, unless a complication is present.

Ms. Gardner received a B.N. degree from U of Manitoba in 1967. She has worked with the VON as a district nurse, health nurse in an industrial setting, as Home Care referral nurse, and as the visiting nurse in a special surgical home visiting program for ehildren. She is presently employed on a part-time basis as the VON nurse making home visits for the Grace Hospital's weekend, tubal ligation program in Winnipeg, Manitoba.

The VON nurse makes a follow-up visit to each woman on the day after her discharge from the hospital.

#### **Initial phone contact**

In her initial phone contact with each patient about one week prior to surgery, the VON nurse explains the reasons for a preoperative visit and arranges the time of her visit. She instructs the patient to save her first voided morning specimen, to have all current prescriptions on hand, to visit the hospital with her husband either the day of surgery or earlier to sign the eonsent for sterilization, and to arrange for help at home following her discharge.

During this initial phone contact, the nurse gives the patient an opportunity to ask any questions that concern her.

#### **Preoperative** visit

The VON nurse's Thursday preoperative visit to each patient might be
best illustrated by her visit to Ms. P.
Ms. G., the VON nurse, met Ms. P., a
33-year-old mother of three children,
on Thursday morning. Ms. P. was
scheduled to enter the Grace Hospital
the next day for a tubal ligation, on the
special weekend program. The nurse
had phoned her earlier in the week
and arranged to visit Ms. P. in her
home that morning. The woman's two
eldest children were in school, and her
three-year-old daughter was watching
"Sesame Street" on television.

Ms. P. and her husband thought about a tubal ligation soon after their last child was born, but they never asked their doctor about it because they thought Ms. P. was too young. However, their doctor approached the subject with Ms. P. when she visited him for her last annual examination.

Mr. and Ms. P. were pleased that a tubal ligation was possible, and asked their doctor to make all the necessary arrangements with the hospital.

As she waited for the nurse to arrive, Ms. P. was busy washing her kitchen floor, because she knew she wouldn't be able to do it for a couple of weeks after surgery. When she thought about her impending surgery, she got "butter-

flies" in her stomach. The only time she had had an anesthetic was for removal of her tonsils when she was 10 years old; she didn't remember much about it, except that she was "very sick to her stomach."

She hoped the nurse would be able to answer all the questions she had; when she had seen the doctor for her physical checkup 10 days before, he seemed in such a rush that she didn't want to bother him with any questions.

The nurse arrived and talked briefly with Ms. P. and her daughter. The two women then sat down at the kitchen table, where they could be relatively private. The nurse first clarified for Ms. P. the time she should report to the hospital and the location of the admitting department. Mr. P. planned to take his wife to the hospital the next morning; they would both sign the consent for sterilization then.

The nurse next explained to her patient the sequence of events that would take place from the time she arrived in the admitting department to the time she returned to her own room following the recovery room. Ms. G. made this discussion quite detailed because of the patient's inexperience with surgery. She sensed Ms. P.'s apprehension about the unknown by the questions she asked.

The nurse asked her about her know-ledge of the actual procedure and its results, and Ms. P. admitted how limited her information was. The nurse then proceeded to explain, through a diagram, what is done to the fallopian tubes during surgery and how this procedure prevents conception. She also explained that the ovaries and uterus continue to function after surgery, just as if nothing had been changed. The nurse took the opportunity to explain to her patient about the abdominal incision, sutures, and dressing.

Ms. P. was glad the nurse had come to see her. So many things had been eleared up in her mind and she felt more relaxed about the whole event. She had been wondering if the surgery would change her periods in any way or even bring on an early menopause.

She hadn't been sure what would happen to the egg after ovulation if her tubes were closed off. A friend had told her she would gain weight after a tubal ligation, and she had been relieved to learn this was not so.

Someone else had told her she would have to wait several months before her surgery was 100 percent effective, but with Ms. G.'s explanation she realized this also was incorrect.

The nurse told Ms. P. how she would feel postoperatively, and stressed the need for adequate rest and the avoidance of strain to the abdomen.

Ms. P. had arrranged for her mother to come to stay for the first week after her return from hospital. However, had she been unable to acquire her own help, the nurse would have put her in touch with the VON home-help service, where homemakers are available at a rate in keeping with the family income.

Ms. P. wanted to know when she could resume her normal household duties, "keep fit" exercises, and curling. She wondered if she could climb stairs, as she lived in a two-story house. By now, she was comfortable with the nurse, so she felt free to ask when she and her husband might resume their marital relations.

Although OR regulations pertaining to fasting and removal of makeup, jewelry, and nail polish had already been explained in the letter Ms. P. had received, the nurse made sure they were fresh in her mind. Visiting regulations had also been stated in the letter, but Ms. P. wondered if her children were going to be allowed to visit her. She was particularly apprehensive about leaving her three-year-old; they had never been separated before.

The nurse asked Ms.P. information to complete a Kardex and a preanesthetic questionnaire. When Ms. P. brought out the medications she was taking, she began to explain to the nurse the problems she had been having lately while taking the birth control pill. When her doctor suggested a tubal ligation, she was relieved because she just couldn't foresee another 20 years taking the pill.

Finally, the VON nurse performed a hemoglobin estimation, a urinalysis, and a shave prep. She left Ms. P. with a glycerin suppository and a disposable glove, and instructed her how to give herself the suppository that evening. She also left her patient with a one-ounce bottle of pHisoHex to be used for a five-minute scrub to the shaved area just before going to hospital the next day.

The nurse completed Ms. P.'s records, enclosed them in an envelope, and gave it to her to hand to the RN who would be caring for her in hospital.

#### The surgery

After completing her six preoperative visits on Thursday, the VON nurse always phones the RN who cares for the patients preoperatively on Friday. She relays to her any information about a patient that she feels will be pertinent to the woman's care the next day. By telling the RN that Ms. P. had been on a diuretic, the VON nurse knew that her electrolyte balance would be checked before surgery.

At the Grace Hospital the usual surgical approach for a tubal ligation is through an abdominal incision. For about a year, some doctors have been performing the procedure through the vagina for their patients. This latter approach alters the postoperative recovery slightly, because there is no incision.

On Friday afternoon, the hospital nurse, in turn, phones the VON nurse to tell her of anything she should know about the patients before her follow-up visit.

#### The postoperative visit

When the VON nurse visited Ms.P. at home Monday, the day after her discharge, Ms. P.'s mother answered the door and explained her daughter was resting in bed. A quick glance through the house as she went to the bedroom told the nurse that Ms. P.'s mother had the household running smoothly.

The first thing Ms. P. told the nurse was that she never dreamed she would be so tired or so sore! She was glad her mother was there because she could

never have managed alone.

Ms. G. made sure her patient had filled her prescription for an analgesic; she learned that the woman's discomfort was mainly incisional, although she still had some gas pains. The nurse also learned that Ms. P. had not had a bowel movement postoperatively; she instructed her about taking a mild laxative that evening. Ms. P. was having no problems voiding and had no unusual vaginal discharge.

The VON nurse checked Ms. P.'s dressing and discovered it was not soiled but was pinching her: she changed it to a smaller one. The doctor had told Ms. P. to return to his office the next Thursday, so the nurse made sure she had an appointment at the office for the removal of her sutures. She reminded Ms. P. to take only sponge baths until her sutures were removed.

Ms. P. got up to accompany the nurse to the door, and the nurse showed her the best way to get up when one has an incision. She also reminded her patient about posture.

#### Evaluation

Ms. P.'s sentiments, as she said goodbye to the VON nurse, best express the sentiments of most patients the nurse visits.

Ms. P. told the nurse how much she appreciated her visits and her concern. She said everyone in the hospital seemed so interested and concerned about her, too. She felt relaxed having the nurse visit her in her own home, and this made it easy for her to have all her questions answered. There had been so much she had not known about her surgery, and receiving all the information she did, made her less apprehensive.

Being prepared together and being able to talk with the other five patients, had made Ms. P. positive she and her husband had made the right decision. The individual attention made all of them feel very special.

Ms. P.'s children were affected only slightly by her hospitalization, as she was in hospital over a weekend when her husband was home from work to care for them. Her children were happy to have her home and, with her mother's help to come home to, she was glad not to be away any longer than two days. Ms. P. wondered if this was being done for other types of surgery.

# Auscultation of the chest — a clinical nursing skill

Nurses proficient in auscultation can recognize early manifestations of pulmonary distress. These can often be reversed by conservative therapy, before a patient develops serious respiratory complications.

#### **Gail Slessor**

Auscultation of the chest is not a mysterious technique to be carried out only by nurses in special care areas or by the physician on his rounds. Every nurse working in a clinical area should become proficient in this method of clinical assessment, as he or she is the member of the health care team having the greatest opportunity to make serial examinations and detect changes.

#### Indications for chest auscultation

Patients who are experiencing shortness of breath or dyspnea, who are
coughing, wheezing, or expectorating
sputum should have chest sounds
checked at frequent intervals, as these
are obvious symptoms of pulmonary
involvement. In other patients, however, chest complications may occur
insidiously and go unnoticed until more
prominent clinical signs are apparent,
and the patient is in serious difficulty.
When observations are made early, the

process can often be corrected with conservative therapy, and the development of respiratory insufficiency or other serious complications may be prevented.

Decreased activity, incomplete lung expansion, and pooling of secretions render the patient on bed rest particularly prone to respiratory complications.

The cardiac patient is predisposed to respiratory complications when left ventricular failure is present. This leads to pulmonary engorgement, increased capillary pressure, and escape of fluid into the alveoli, causing impaired gas exchange.

Imposed or therapeutic immobilization of the orthopedic patient predisposes to hypoventilation and pooling of secretions in dependent areas of the lung. Pulmonary fat emboli are apt to develop in patients with fractures of long bones. Patients in traction or hip spica casts cannot easily be turned from side to side—this also leads to development of atelectasis and pooling of secretions.

The postoperative patient with abdominal or chest surgery often splints his breathing because of pain in the operative site. This problem is compounded by the administration of

Ms. Slessor, a graduate of the Misericordia General Hospital, Winnipeg, has had experience in operating room, emergency room, and intensive care nursing. She is currently surgical nursing supervisor at the Winnipeg General Hospital, narcotic analgesics that may depress respiration. The development of atelectasis, retention of secretions, and, eventually, pneumonia are the consequences.

Shock with circulatory overload (cardiogenic) or circulatory depletion (hypovolemic) must not be overlooked as a possible cause of pulmonary difficulties. In these situations, an additional burden is placed on the lungs to supply greater amounts of oxygen and to excrete a larger volume of carbon dioxide. Even a small degree of pulmonary congestion or retention of secretions can reduce respiratory capacity to where it cannot compensate for the metabolic acidosis that occurs.

#### The lungs and acid-base balance

Although the kidneys are usually considered the major organic acid waste disposal organs of the body, pulmonary function is more important in terms of acid-base equilibrium. The kidneys effectively excrete approximately 100 milliequivalents of nonvolatile acid per 24 hours, whereas the lungs excrete some 13,000-22,000 milliequivalents of volatile acid (carbon dioxide) per 24 hours.

This alone explains why patients with respiratory failure become critically ill within a few hours or, in severe cases, minutes. It also emphasizes that, with increased vigilance in detection of pulmonary problems, nurses can initiate action early and prevent serious complications of this nature.

#### Vesicular breath sounds

Normal, or vesicular, breath sounds result from minor turbulances when air moved during respiration is de-**APRIL 1973** 

flected by the bends and bifurcations of the tracheobronchial tree. Air drawn into the lungs during inspiration is channeled into smaller and smaller airways, resulting in turbulent vibration that can be heard at the chest wall with a stethoscope. These sounds are more pronounced during the inspiratory phase of respiration because the air is being conducted into increasingly smaller channels at a rapid flow rate due to the shorter time interval for inspiration.

Expiration takes one and one-half times longer than inspiration and is normally passive due to relaxation of respiratory muscles. Air flows from smaller to larger airways, thus turbulence is significantly less during expiration, and less sound is transmitted to the chest wall.

To become familiar with the quality of normal chest sounds, constant practice in auscultation is needed, and comparison of observations must be made with someone who is experienced in the art. Nurses in most intensive care units, recovery rooms, and emergency rooms, as well as the interns, residents, and staff doctors, are proficient in these skills and are usually available for consultation. Comparison can also be made with doctors' notations in the progress notes. A teaching stethoscope allows accurate comparison by "teacher" and "student," as both are listening simultaneously.

#### Adventitious breath sounds

Once normal breath sounds have been recognized, abnormal or adventitious ones are more easily identified. These occur as a result of a pathological process within the lung or tracheobronchial tree. The more common adventitious breath sounds are:

Rhonchi (from the Greek, to wheeze, and pronounced ronki) are wheezy or whistling musical sounds generally heard during expiration. They are due to the shortening and narrowing of the airways during this phase of respiration.

Their pitch depends on the size of the bronchus in which they are produced — the smaller the lumen of the bronchus, the higher the pitch — as the sound results from air flowing very quickly through a narrow channel. Narrowing can be due to partial obstruction with secretions or with spasm of the smooth muscle of the bronchus (bronchospasm). The sound can often be elicited in people with asthma, bronchitis, and other forms of chronic obstructive lung disease. Rhonchi can also be heard during forced expiration, following coughing or tracheal suctioning.

Râles (from the French, to rattle, and pronounced rals) are short, interrupted, bubbly sounds generally heard during inspiration. Their pitch also depends on the size of the bronchus in which they are produced. Râles are heard most frequently during inspiration because, as air is drawn into the lungs, secretions that have collected along the walls are drawn in the same direction. These secretions accumulate in the smaller airways and create a building effect as air is inspired through

Crèps or crepitations may be used as synonyms for râles, although they more often describe the finer crackling sound of bubbles breaking in the

terminal airways. This sound resembles that of cellophane being crumpled.

Coarse breath sounds are those of increased intensity heard in the absence of specific abnormal sounds, such as râles or rhonchi.

Bronchial breathing results in a loud, harsh, brassy sound resembling the sound heard when a stethoscope is placed directly over the trachea. Bronchial breathing is encountered when there is an area of consolidation of lung between the chest wall and a patent bronchus. Normally, the lung tissue has millions of tiny air spaces, but, in consolidation, they fill with secretions and the lung tissue becomes "solid." The increased intensity of sound results from the transmission of normal air flow vibrations from the bronchus to the chest wall by solid tissue rather than being muffled by the air spaces of normal lung tissue.

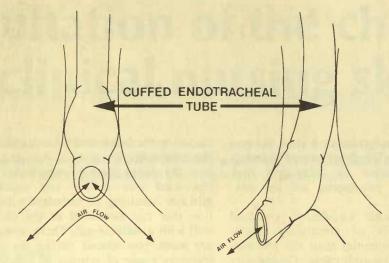
Additional and specific characteristics of bronchial breathing are equality of pitch, intensity, and duration during inspiration and expiration, and a brief interval of silence between the end of inspiration and the beginning of expiration.

Other observations

Observations other than breath sounds can be made during auscultation of the chest.

Atelectasis: Collapse of alveoli in local or generalized areas can be recognized by the decreased intensity of breath sounds or, if there is complete atelectasis, by the absence of breath sounds over that area.

Pleural rub: If a coarse, creaky, leathery sound is heard in the latter part of inspiration and early part of expiration, it is caused by the friction of inflamed pleura rubbing



NORMAL POSITION

Provides good ventilation

to both lungs.

"SLIPPED" ENDOTRACHEAL TUBE.

Left lung not ventilated or protected against aspiration.

together, as in pleurisy. The rub is usually heard in the lower lateral areas of the chest wall, as this is the area of greatest excursion (chest expansion).

Equality of air entry

By comparing the breath sounds on one side of the chest with those in the same location on the other side of the chest, one can determine the equality of air entry, the amount of ventilation occurring, or the degree of impairment of one side.

This determination is important in all patients, especially those with chest trauma and/or with endotracheal tubes in place. The trauma patient may have decreased air entry at the site of injury due to contusion, hematoma, hemothorax, pneumothorax, or the presence of a flail segment. These may not be observable on inspection, but auscultation will indicate the location and the degree of impairment of ventilation.

An endotracheal tube is often necessary in emergencies, in short term management after anesthesia, or for ventilatory assistance. These tubes are difficult to secure firmly

in place, and they can slip further into the tracheobronchial tree. When this occurs the tube usually slips into the right main bronchus (Figure 1) as it is nearly vertical. If this happens and the cuff is inflated to guard against aspiration, the left lung is not protected, and the right lung only is ventilated.

The air remaining in the left lung is soon absorbed and complete atelectasis may result. Reexpansion of the left lung can be difficult and time consuming, as higher than normal inspiratory pressures are needed to separate the adherent alveolar walls. Intermittent positive pressure breathing is then required for some time.

Auscuttation should be carried out at regular intervals, particularly after turning the patient with an endotracheal tube, for early recognition of a slipped tube. Repositioning of the tube can then be accomplished quickly and easily before serious atelectasis develops.

#### Tracheal suctioning

Chest auscultation prior to tracheal suctioning can help in locating secretions. The suction catheter can then be directed into the appropriate side of

**APRIL 1973** 

42 THE CANADIAN NURSE

the chest. Listening again after suctioning is valuable in determining the effectiveness of the procedure. It can often prevent unnecessary suctioning, particularly when the patient's distress is due to spasm rather than to secretions. Knowing the location of secretions and/or bronchial breathing is also valuable in deciding how to position the patient to drain the appropriate lobes more effectively.

#### Effectiveness of bronchodilators

Chest auscultation before and after the administration of aerosol bronchodilators allows the nurse to assess the improvement in air entry, and the reduction of adventitious breath sounds. This information is valuable in determining the effectiveness of such treatments.

#### Enlist patient's cooperation

The ease with which chest auscultation is carried out and the quality of the information obtained depend on the patient's cooperation. It is important to have the patient take slow deep breaths through his mouth. Close observation is necessary to ensure the patient is not hyperventilating during this examination. Ideally, the patient should be in a sitting position so that anterior, posterior, and lateral aspects can be auscultated more easily.

Auscultation should be carried out in an organized sequence, commencing with the lung bases, which can be auscultated only in the lower posterior part of the chest wall. Side-to-side comparisons are made as the stethoscope is moved up the chest wall. (Figure 2) The anterior and lateral areas are similarly examined.

If râles or creps have been heard in the bases, this area is reexamined to determine if these have cleared following the patient's deep breathing exercises. If these sounds are still present, the patient is encouraged to **APRIL 1973** 

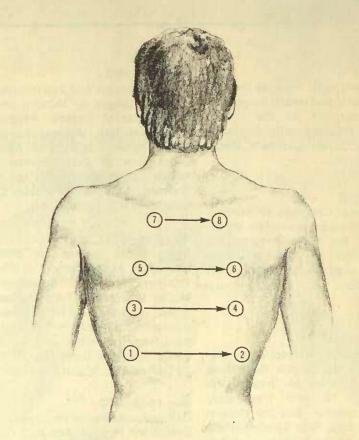


FIGURE 2: Beginning at bases, the stethoscope is moved from side to side as shown.

cough, and another assessment is made. Failure of this area to clear is an indication that secretions are pooling, and further steps can be taken to aid in clearance and to prevent progression.

Active deep breathing (10 breaths), changes of position from side to side. and voluntary coughing every hour while awake are a few simple measures that are quite effective in preventing atelectasis and pooling of secretions. If these measures are not sufficient, nasotracheal suctioning, intermittent positive pressure breathing, and posturizing and percussion may be helpful.

#### Summary

Auscultation of the chest is a method of clinical assessment that provides the nurse with invaluable information about her patient's respiratory status. The technique is neither difficult nor complicated, but requires perseverence and continued practice. It is a skill that can and should be mastered by all nurses who work in clinical areas. Pre-

requisites are a knowledge of the characteristics of normal and abnormal breath sounds, a good quality stethoscope, and most important, a willingness to learn.

Chest auscultation should not be restricted to those patients who have known or obvious respiratory problems. All patients should have their chest sounds assessed initially to establish a baseline from which to determine improvement or deterioration.

#### **Bibliography**

Andreoli, Kathleen G. et al, Comprehensive cardiac care; a handbook for nurses and paramedical personnel. St. Louis, Mosby, 1968, p.13-4.

Smith, Jay W. Manual of medical therapeutics, 19ed, Boston, Little, Brown, 1969, p.47-56.

Cherniack, R.M. and Cherniack, L. Respiration in health and disease. Philadelphia, Saunders, 1961. p.137-41, 323-5.



# dates

#### April 26, 1973

A special session on "Nurses Involvement in Smoking and Health Programs" has been planned for the annual meeting of the Canadian Public Health Association, Queen Elizabeth Hotel, Montreal, Quebec.

#### Arpil 26-28, 1973

Fourth National Congress on Medical Ethics, The Washington-Hilton, Washington, D.C. For further information, write to: Dept. of Medical Ethics, American Medical Association, 535 North Dearborn St., Chicago, Illinois 60610, U.S.A.

#### April 27-28, 1973

Refresher course in respiratory diseases, sponsored by the Registered Nurses' Association of Ontario, the York-Toronto TB and Respiratory Disease Association and the Ontario Thoracic Society, Four Seasons-Sheraton Hotel, Toronto. Subjects included in the program will be childhood lung diseases, allergic lung diseases and industrial lung diseases. Application forms may be obtained from the York-Toronto TB and RD Association, 157 Willowdale Ave., Willowdale, Ont.

#### May 3-4, 1973

Workshop for directors of nursing service in Nova Scotia "The Role of the Nursing Service Administrator in 1973," Halifax. Resource person: Norma Wiley, Director of Nursing, McMaster University, Hamilton, Ontario. Registration fee: \$20. For further information, write to: Dorothy Miller, Public Relations Officer, Registered Nurses' Association of Nova Scotia, 6035 Coburg Road, Halifax, Nova Scotia.

#### May 3-5, 1973

Intensive Therapy Approach (ITA) Seminar of interest to doctors, nurses and other paramedical personnel. Registration limited. Direct enquiries to: Ms. Karin Davies, 34 Hiley Avenue, Pickering, Ontario.

#### May 6-10, 1973

1973 convention and 21st anniversary, National League for Nursing and National Student Nurses' Association, Convention Hall, Minneapolis, Minnesota. Theme: "Coming of Age...A Declaration of Independence." For further information, write to: Arline Brennan, NLN, 10 Columbus Circle, New York, N.Y. 10019, U.S.A.

#### May 7-11, 1973

Postgraduate course in childbirth education, McGill School of Physical Therapy, Montreal. Sponsored by McGill University. This bilingual program is designed for paramedical personnel interested in the obstetrical field. Registration fee: \$50. Application forms available from: Ms. C. Morse, 73 Dunrae Ave., Mount Royal 304, P.Q.

#### May 13-16, 1973

National conference on "The Child in Sports and Physical Activity," Queen's University, Kingston, Ontario. For further information, write to: Professor R. Carnegie, School of Physical & Health Education, Queen's University, Kingston, Ontario.

#### May 13-16, 1973

Workshop on "Evaluation of Student Nurse Clinical Performance," sponsored by the University of Western Ontario Summer School and Extension Department. Tuition fee: \$125. For further information, write to: Summer School & Extension Dept., U. of Western Ontario, London 72, Ontario.

#### May 16-17, 1973

Ambulatory Pediatric Association, 13th annual meeting, San Francisco Hilton, San Francisco, California. For further information, write to: Elizabeth Hillman, M.D., 2300 Tupper St., Montreal 108, Quebec.

#### May 22-23, 1973

Workshop on "International Issues in Nursing" to be held at the University of California following the International Council of Nurses Congress. Nurses from several countries will present papers. Faculty from the U. of California will review the school's programs leading to baccalaureate, masters, and doctoral degrees. Nursing service in university hospitals will also be discussed. For further information, write to: Marjorie S. Dunlap, Dean, School of Nursing, U. of California, San Francisco, Calif. 94122, U.S.A.

#### June 10-13, 1973

Canadian Association of Neurological and Neurosurgical Nurses, annual meeting, Hotel Bonaventure, Montreal, Quebec. For further information, write to: Ms. Gerrie Hart, Apt. 1902, 625 Milton St., Montreal 130, Quebec. Membership information may be obtained from: Ms. Lynne Baldwin, Apt. 203, 9535 — 165th St., Edmonton, Alberta.

### June 11-15, August 27-31, 1973, February 18-22, 1974

New Canadian series of one-week courses "TB? Today??" for nurses involved in prevention, control and management of tuberculosis. Courses will be co-sponsored by the U. of Ottawa School of Nursing and the Canadian Tuberculosis & Respiratory Disease Association. Each course limited to 36 persons, grouped according to present employment categories. For further information, write to: Ms. Lorette Morel, Canadian Tuberculosis and Respiratory Disease Association, 345 O'Connor St., Ottawa, Ontario K2P 1V9.

#### June 17-23, 1973

18th International Hospital Congress, 6th National Convention, and 30th Assembly, Canadian Hospital Association, Place Bonaventure, Montreal, Quebec.

#### June 25-27, 1973

Emergency Nurses' Association of Ontario three-day conference, Royal York Hotel, Toronto, Ontario. Enquiries may be directed to: Ms. A.M. Harris, 30 Ellen Street, Brampton, Ontario.

**APRIL 1973** 



# in a capsule

#### Credit cards beat bank robberies

It's hard to believe that the loss of money from fraudulent use of credit cards is three times higher than the loss from bank robberies and related offences. Perhaps this is because bank holdups are more dramatic and always make the news.

Because more than 100,000 credit cards, amounting to a \$3 million loss for the companies concerned, go astray in Canada each year, these companies are going to ask the government to amend the Criminal Code to provide for credit card crimes.

This information comes from the November 6, 1972 View from Ottawa. According to this legal source, no mention of credit cards is made in the Criminal Code, although a fraudulent user who impersonates a credit card holder, forges a signature, or acts under false pretences can be charged on these counts. But anyone who "merely traffics in eards, or buys them from one source and sells to another" cannot

be prosecuted.

Legitimate purchases by card holders are estimated at \$1.5 billion, and loss by fraud, 0.2 percent of total business. However, the View from Ottawa notes that the credit card industry is growing at a rate of some 10 or 15 percent each year, and if crimes keep pace, card theft would become a significant criminal activity.

Recycling abandoned automobiles

Some 100,000 unsightly scrap vehicles in Saskatchewan, which now litter the landscape throughout the province, are about to be collected by a contractor, flattened, and taken to Regina for recycling.

This news is recycled from the November 1972 issue of Argus-Journal, published by the Public Service Alliance

of Canada.

According to our source, it should take about three years and some \$16 per unit to finish the project, which is financed by a \$1 addition to the cost of each vehicle license.

Health food poisonings

The November 14, 1972 issue of The Medical Post reported that a number of cases of poisoning have occurred from ingesting apricot kernels brewed into a drink or purée. Symptoms noted were abdominal discomfort, rapid heart beats, headache, dizziness, and impaired

A warning has been issued about the apricot kernels. According to Dr. S.B. Warner at the California State Health Department in Berkeley: "Since this and similar products are widely distributed in health food stores for reputed nutritional and medicinal value, the possibility of disease from a large number of kernels should be recog-

The Medical Post story also mentions that the seeds and pits of some other fruits — even apples, cherries, and peaches - have amygdalin, a chemical the body can change into cyanide. Amygdalin, the Latin name for almond, "can be made harmless by proper preparation, but few food faddists bother," the story concludes.

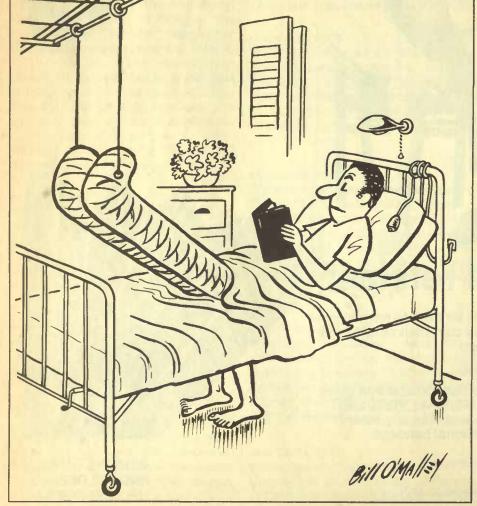


Once again we have Bay Views, published by Western Memorial Hospital in Corner Brook, Newfoundland, to

thank for the following humor. A man complained to the divorce

court judge that his wife was driving him mad with her constant chatter. "Under the constitution of the U.S.A., she had every right to talk," the judge remarked. "That may be," the husband replied, "but the U.S. has a constitution that can stand it. Mine can't.

"For our anniversary," said the pretty young wife, "let's give each other sensible gifts like ties and fur coats."



# Here is a new, fast and sterile way to prepare Xylocaine infusions

for life threatening arrhythmias



# **Xylocaine®**

(Lidocaine Hydrochloride Injection, Astra Std.)

ne Gram

- The special 5 ml transfer syringe contains 200 mg/ml Xylocaine and can be added to infusion set-ups without removing solution from infusion flask or bag
- Cuts preparation time in half
- Easy and convenient to use
- Adds another link to the sterility chain
- Disposable
- Clearly labeled for positive safeguard against error

ASTRA Pharmaceutical Division, Mississauga, Ontario



## names



Wyeth Ltd./Ltée, has announced the appointment of Louise D'Amour as director of infant nutrition and family planning services. Ms. D'Amour, who received her basic nursing education

in Moncton, New Brunswick, worked four years at the Notre-Dame de l'Espérance Hospital in Montreal prior to coming to Wyeth. She is now located at Wyeth's Toronto office.

Jane Clouston Hutchings of Cow Head, Newfoundland, was made a Member of the Order of Canada in December 1971, in recognition of her distinguished service to nursing.

Ms. Hutchings (R.N., Homeopathic - now Queen Elizabeth — Hospital school of nursing, Montreal) became district nurse at Cow Head in 1949. and was responsible for the five settlements between Parson's Pond and Sally's Cove where, at the time, there were no roads.

After her retirement from active nursing in 1970, Ms. Hutchings received an honorary membership in the ARNN in 1971.



Phyllis Lyttle



Edna Walsh

Phyllis Lyttle, director of public health nursing, has retired after 34 years with the Nova Scotia department of public health. Alert to emerging trends, she has always encouraged her staff to accept challenges and to move into

new areas of public health nursing.

A graduate of Payzant Memorial Hospital school of nursing, Windsor, N.S., Ms. Lyttle earned diplomas in public health nursing at MeGill University, and administration and supervision at the University of Toronto.

Ms. Lyttle has served as president of the Registered Nurses' Association of Nova Scotia and the N.S. branch of the Canadian Public Health Association. She has had conferred on her a life membership in the former and an honorary membership in the latter association.

Edna Walsh (R.N., Halifax Infirmary school of nursing; B.Sc.N.Ed., U. of Ottawa; Ed.M., Teacher's College, Columbia U.) has been appointed director of public health nursing, Nova Scotia department of public health, to succeed Phyllis Lyttle.

Prior to joining the department in 1958 as consultant in maternal and child health, Ms. Walsh taught obstetrics at the Halifax Infirmary. From 1966 until resuming her studies, she was nursing counselor with the Nova Scotia Hospital Insurance Commission, and only recently rejoined the department of public health.

Ms. Walsh is active in the Registered Nurses' Association of Nova Scotia and is currently a member of the committee on research and the curriculum council,

Margaret A. Brayton (SRN, RGN, SCM, RSCN, NA (hosp.) cert.) has been appointed secretary of the Commonwealth Nurses' Federation. She took up her appointment in London, January 1, 1973.

Ms. Brayton was the regional nursing officer to the South Eastern Regional Hospital Board in Scotland from 1960 until her recent appointment. Active in national and international nursing for a number of years, she has visited and observed hospital and health service agencies in Canada, India, Pakistan, Hong Kong, Singapore, and Malaysia.

In 1953, Ms. Brayton won a British Commonwealth War Memorial Fund Scholarship to study pediatric nursing in Canada and the United States.

The Commonwealth Nurses' Federation, established in October 1971, has the aim of advancing nursing in the interest of people in Commonwealth countries. The new secretary's first task is to establish the federation office and to make contact with the five regional representatives and national nurses' associations belonging to the federation.

Elizabeth Ann Taylor (R.N., Victoria H., London, Ont.; B.Sc.N., U. of Western Ontario, London; M.S.N., U. of British Columbia, Vancouver) has been named director of nursing for the East York Health Unit in Toronto. Ms. Taylor previously worked at Vancouver General Hospital as executive assistant to the director of nursing.

Florence Sachi Shiraishi has been appointed educational consultant for the nursing division of the Toronto Department of Public Health.



A 1968 graduate of McMaster University School of Nursing in Hamilton, Ontario, Ms. Shiraishi was appointed a staff nurse in the nursing division, Toronto Department of Public

Health in 1968. She has also had experience as an assistant supervisor and assistant educational consultant. She is a member of the Registered Nurses' Association of Ontario and the Ontario Public Health Association.

Mary Barbara Willet (R.N., and B.Se.N., U. of Toronto school of nursing) has been appointed consultant in school nursing with the nursing division, Toronto Department of Public Health.

Since 1944, Ms. Willet has been a staff nurse, assistant supervisor, and district supervisor with the department. She is a member of the Registered Nurses' Association of Ontario and the Ontario Public Health Association.



Mary Willet



Marguerite Williams

Marguerite C. Williams (R.N., Toronto General H.; B.Sc.N., U. of Toronto; M.S., Boston U.) has been appointed nursing consultant in rehabilitation and adult health in the nursing

division, Toronto Department of Publie Health.

In addition to private duty, Ms. Williams has worked as a staff nurse and assistant head nurse in the obstetrical and the admitting departments at Toronto General Hospital. From 1948 to 1962, she was a staff nurse and assistant supervisor with the Victorian Order of Nurses. She took a one-and one-half year leave of absence to gain experience in the geriatric rehabilitation unit of the West Middlesex Hospital, London, England. From 1963 to 1971, she was a clinical nurse, public health nurse, and nursing consultant with the Ontario Alcoholism and Drug Addiction Research Foundation. Her responsibilities included part-time teaching in the faculty of nursing at the University of Toronto.

Ms. Williams is a member of the Registered Nurses' Association of Ontario, Ontario Public Health Association, Canadian Nurses' Foundation, Nursing Archives Association, American Public Health Association, American Society of Political and Social Science, and the Sigma Theta Tau hon-

or society in nursing.

The following senior nursing staff appointments have been announced at University Hospital in London, Ont.



Roberta Rivett



Ann Ford

Roberta Rivett (R.N., University Hospital, Saskatoon, Sask.; B.Sc.N., U. of Ottawa; M.Sc.N., U. of Western Ontario, London) is assistant director, nursing services.

Ms. Rivett's experience includes positions as staff nurse at University Hospital, Saskatoon, and Prince County Hospital in Summerside, Prince Edward Island; assistant head nurse at Scar-borough General Hospital, Searborough, Ontario; and administrative supervisor at Ottawa Civic Hospital, Ottawa. She is an active member of the Registered Nurses' Association of On-

Ann Ford (R.N., St. Michael's School of Nursing, Toronto; B.Sc.N.Ed., U. of Ottawa; M.Sc.N., U. of Western Ontario, London) is assistant director, staff education, at University Hospital, London.

Ms. Ford has worked as staff nurse at St. Michael's Hospital in Toronto and at the Montfort Hospital in Ottawa; clinical instructor and director of the registered nursing assistant program at St. Michael's School of Nursing in Toronto; and inspector with the College of Nurses of Ontario.

She is an active member of the Registered Nurses' Association of Ontario and has served on provincial nursing

committees.



Christine Emrich (R.N., St Mary's H. School of Nursing, Kitchener) has joined a team of Canadians serving with MEDICO, a service of CARE, at a hospital complex in Surakarta (Solo)

in Central Java. In addition to caring for patients, she will help to educate

Indonesian nurses.

Ms. Emrich has worked in Moose Factory and Port Harrison and at hospitals in Kelowna, B.C., Sudbury and London, Ontario, and the West Indies. For the past three years, she has worked at the Donwood Institute in Toronto.

Brenda Schenkel (R.N., Nightingale School of Nursing, Toronto; dipl. PHN, U. of Windsor, Windsor, Ontario) has been appointed a district nurse for the Ontario Society for Crippled Children in London, Ontario. She is covering the counties of Middlesex, Oxford, Perth, and Bruce.

Ms. Schenkel was a public health nurse in Ontario with the Elgin-St. Thomas health unit from August 1969 to June 1972. She has been vice-president and president of the Elgin-St. Thomas nurses' association.

Cynthia Cameron has been appointed director of the Vanier School of Nursing, Ottawa, effective February 1, 1973. A graduate of the Atkinson School of Nursing, the Toronto Western Hospital, she earned her B.A. degree at Queen's University, Kingston, and M.Sc.N. at Boston University,

Before joining the Vanier School of Nursing in 1969, Ms. Cameron lectured at the U. of Ottawa School of Nursing and at the Nightingale School of Nursing in Toronto. Active in professional circles, she is currently secretary of the Ottawa West chapter of the RNAO, and finds time for leadership in an experimental program of the Boy Scouts of Canada for boys aged five to seven, and for participation in winter sports.

**Next Month** 

## The Canadian Nurse

- The Patient as a Partner
- Idiopathic Edema
- How CNF Scholars Are Selected
- Argon Laser Photocoagulation for Retinal Vascular Disease



Photo credits for **April 1973** 

Cover: Permission granted by Canada Post Office, Postage Stamp Division, Ottawa

John Evans, Ottawa, p.9

Comité Histoire de L'Hôtel-Dieu de Montréal, p. 10

McMaster University, Health Sciences Centre, Hamilton, Ontario, p.29

# research abstracts

The following are abstracts of studies selected from the Canadian Nurses' Association Repository Collection of Nursing Studies. Abstract manuscripts are prepared by the authors.

Harrison, Fernande P. A conceptual model for the provincial nursing consultant in Alberta. Edmonton, Alta. 1972. Thesis (M.H.S.A.) U. of Alberta.

The objective of this study was to develop a conceptual model for the position of provincial nursing consultant (PNC) in the Alberta Hospital Services Commission. As a beginning basis for developing the model, the investigator provided a short historical background of the development and nature of professional consultative services, followed by an outline of some of the socio-political forces related to the emergence of consultants in the business and health fields and, more specifically, to the development of consultative services within the nursing profession.

A major tenet underlying this study was that societal forces, including political and economic exigencies, influence professionals as change agents and suppliers of knowledge within governmental agencies. A further tenet was that leadership patterns and the interclationships of professional groups are two centrally important internal factors affecting the roles of professionals in the employ of official agencies.

Consultation was interpreted as being a process having both educational and helping dimensions, the major principles underlying the process being that 1. a voluntary relationship, and 2. two-way communication exist. Critical to the success of the consultative process are the advisory capacity of the consultant and the "take it or leave it" quality of the consulting service.

The model for the position of PNC in Alberta outlines the liaison and coordination functions of the PNC vis-à-vis personnel within other provincial health agencies, hospitals, and related facilities, as well as with federal nursing consultants, professional associations, and universities and their professional schools. The planning

and evaluative functions are deemed to be vital to the roles of the PNC. The education functions, comprising self-education, team work participation, and interpretative activities, represent the core responsibilities.

The model reflects a high emphasis on research consumer skills and the PNC's responsibility for innovation as opposed simply to being an implementer of existing standards. Although the model is tailored to the needs of the Alberta Commission, the study is relevant to the whole area of health services consultation.

Rivett, Roberta E. A study to develop instruments to evaluate the effectiveness of a post-diploma program in nursing. London, Ont., 1972. Thesis (M.Sc.N.) U. of Western Ontario.

The purpose of the study was to develop instruments with which to evaluate the effect of a series of short post-diploma intensive care nursing courses on the clinical performance of nurses caring for patients in intensive care units.

In development of the three instruments — the Intensive Care Nursing Competency Model, the Expectations Rank Order Scale, and the Personal Data Inventory, several methods were employed. These included: assessment of evaluative instruments in published and unpublished literature; utilization of the findings of the study upon which development of the intensive care nursing program was based; utilization of the expertise of consultants in nursing, data processing, statistics and education; interviews with course participants and their employers in the home hospitals; testing draft instruments through administration to course participants and their employers in the home hospitals.

Three instruments constituted the outcome of the study: 1. The Intensive Care Nursing Competency Model utilizes a rating scale through which ratings of the skill level of the subject in 71 intensive care nursing skills are performed. The instrument may be administered to students and also to their employers, before and after a course of the program.

2. The Expectations Rank Order

Scale invites respondents to rankorder their expectations of the intensive care nursing program. Through readministration three months after the course, the extent of satisfaction of these expectations may be identified.

3. The Personal Data Inventory collects biographical information about respondents, and in addition elicits data on several factors believed related to performance change following the program.

Hoeffler, Deborah Margaret. A survey to determine the perceptions of a selected group of head nurses and supervisors concerning the channels of communication existing within a hospital. Scattle, Wash., 1971. Thesis (M.N.) U. of Washington.

A review of the literature documented the importance of effective communication in today's large complex organizations. A study was designed to determine on a limited scale what channels of communication a selected group of nurse administrators used in solving the problems they encountered in their daily work.

It was hoped to determine whether there was a difference between the channels they felt they would use and those they perceived as correct. The other question considered was whether the variables of position, age, educational preparation, or years of experience in the institution appeared to affect their responses.

A questionnaire was administered to the head nurses and supervisors of one Canadian university teaching hospital. Participants were presented with hypothetical situations and five possible solutions.

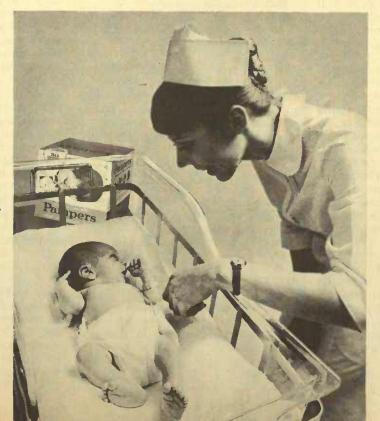
In Part A, respondents ranked their responses from the procedure they would be most likely to follow to the one they would be least likely to follow. In Part B, they ranked their responses from those solutions that they perceived as being most correct to those they perceived as least correct.

Analysis of the data indicated that a majority of respondents differentiated between what they felt they would do and what they perceived as correct. The variable of position appeared to have the greatest effect on response.

# Pampers illoth abreak

## Keeps him drier

Instead of holding moisture, Pampers hydrophobic top sheet allows it to pass through and get "trapped" in the absorbent wadding underneath. The inner sheet stays drier, and baby's bottom stays drier than it would in cloth diapers.



## Saves you time

Pampers construction helps prevent moisture from soaking through and soiling linens. As a result of this superior containment, shirts, sheets, blankets and bed pads don't have to be changed as often as they would with conventional cloth diapers. And when less time is spent changing linens, those who take care of babies have more time to spend on other tasks.

PROCTER & GAMBLE

# books

Anatomy and Physiology Applied for Orthopaedic Nurses, 3ed., by Joyce W. Rowe and Victor H. Wheble. 698 pages. London, England, Churchill Livingstone, 1972. Canadian Agent: Longmans, Don Mills, Ontario.

Reviewed by Audrey E. Pickard, Lecturer, Laurentian University, School of Nursing, Sudbury, Ontario.

This text is written with clarity. The illustrations, neatly labelled, accentuate the material with detail.

The section on "regional anatomy" is excellent. The place for this text is in the clinical area for nurses or students of other disciplines who are assisting in the treatment of patients with orthopedic trauma.

The concise formal language draws the reader to use the text for reference data, which is the objective of the author in "supplying a text well illus-

trated and easy to use."

My Brother, My Sister, by Sister Sue Mosteller. 117 pages. Toronto, Giffin House, 1972.

Reviewed by Karin von Schilling, Associate Professor, School of Nursing, McMaster University, Hamilton, Ontario.

As the title implies, this book is a call for love and attention for the poor, the handicapped, the retarded, prisoners, and the destitute, wherever they are found in this world — our brothers and sisters. The book is an introduction to the devoted work of Mother Teresa of Calcutta, an Albanian nun who founded the community of Missionaries of Charity, and Jean Vanier, a Canadian layman, founder of the international Community of L'Arche. The author offers insight into the development of these worldwide communities and their tremendous contribution to human growth in the spirit of brotherhood and love.

The author, photographer, and designer of the book convey an impressive unity of purpose that carries the message of appeal, happiness, human dignity, and worth on every page of the book, thus encompassing the poor, the retarded, and handicapped into the community of men worthy of our love and attention.

The book is richly illustrated with

photographs, often showing severe destitution and poverty; yet the faces radiate warmth and trust in the love and care offered by the assistants of L'Arche and the brothers and sisters of the Missionaries of Charity. The free verse style of writing is powerful and succinct; it carries the appeal for attention and conveys a message of compassion and commitment to a belief in human dignity and growth, especially among those whom society tends to reject — the poor, the hopelessly sick, and the handicapped.

The book shares its central concern with that of the nursing profession. a commitment to serve mankind in times of need and distress; to be present and to care about and contribute to the quality of life, so that each person can develop according to his deepest aspirations and sustain himself during times of crisis. This book has a message for all nurses, particularly for those who devote their care to the retarded and the handicapped.

On Dying and Denying: A Psychiatric Study of Terminality by Avery D. Weisman. 247 pages. New York, Behavioral Publications, 1972. Reviewed by Susan E. French, Mc-Master University, School of Nursing, Hamilton, Ontario.

This text provides in-depth information about the process of denying as evidenced in ordinary individuals confronted with the personal reality of their own death. Death is viewed as an individual experience occurring within a psychological context.

Denying is identified as a process of which there are five sequential stages, the fifth stage is the fact of denial. Each stage of the process is well defined. Denying is seen as a total process by which an individual res-

ponds to a threat.

Denial, one of the defensive aims of the process, enables the dying individual to avoid reality or to escape confrontation with an unpleasant, threatening event — impending loss of significant relationships and personal extinction. The existence and degree of denial in individuals can be determined only through personal interaction with them.

Interviews were held with 350 patients who were diagnosed as being critically ill and for whom death was imminent. There were two broad categories of patients: individuals who were fatally ill as a result of some disease process, such as cancer or myocardial infarction; and persons in the terminal stage of the "aging" process.

Information regarding the psychosocial stages of fatal illness and terminal old age indicate there is a similar sequence of stages in the process of dying. Analysis of data revealed that a relationship existed between the psychosocial stage of dying and the

degree of denial.

Three levels or degrees of denial were identified. First-order denial consisted of denial of facts of illness. Second-order denial related to denial of implications of illness, and third-order denial was concerned with denial of personal extinction. Excerpts of interviews and analysis of the behavior manifested are used to illustrate the psychosocial stage and the degrees of denial characteristic of that stage.

It was evident that denial was a strategy used by the individual most frequently in the early stages of illness but usually was not maintained in subsequent stages. Hope could be sustained without an unrealistic reliance upon denial. Acceptance and denial were shown to be counter-balanced; as the individual progressed through levels of denial, there was an increase in the level of acceptance. Many of the individuals faced death with equanimity, clarity, and acceptance, whereas others struggled and were filled with anguish and despair. Analysis of the life situations and early patterns of behavior enabled the author to identify factors that influenced the individual's response to impending death.

This book not only complements the work of others who have identified stages and characteristics of an individual's response to the threat of death, it provides additional relevant information regarding a specific response, denial. The clear delineation of the process of denying, the levels of denial, psychosocial stages of denying, and the interrelatedness of denial and acceptance serve to illustrate the role of denial in the adaptive process occurring in the individual who is

confronted with personal extinction. The book would be of interest to all persons who are in contact with dying individuals and/or survivors.

Death and the College Student, edited by Edwin S. Shneidman. 207 pages. New York, Behavioral Publications, 1972.

Reviewed by Betsy LaSor, Assistant Professor, Psychiatric Nursing, University of British Columbia, Vancouver, B.C.

Teaching the subject of death or suieide seems to be approached most comfortably by being academic and objective. In fact, most textbooks on these subjects are fact-filled to add to our own objective knowledge, and it is mostly through the use of the novel that we glimpse the personal feelings leading to self-destruction. This book is an exceptionally good subjective exposure to what death means to college students.

The recent textbook trend of collecting papers is utilized in this book in the form of student essays written for a elass assignment. The focus of each essay was chosen by the student and includes the arts, unusual life situations, philosophy, and personal suicidal experiences.

With one exception, all of the students are from a wealthy, prestigious, eastern American university. The focus is varied and intense. There are few times when one is aware of the economic and social backgrounds of the students. The majority of essays deal with feelings that have no class boundaries and are situations experienced by many college-aged youth. Foot-notes and quotes are infrequently used, which makes one even more sensitive to the personal focus chosen by the students.

These essays are outstanding in the sophistication of the students' conceptualization of death. The depth of feelings these young people relate to living is awesome. The essays do not deal with the tone of life in these tumultuous times, but with the feelings of their own relationship to people, situations, and the variety of significant topics they have been investigating in their studies. Some essays are outward directed in content but could not have been written without some sense of the underlying feeling tones of hopelessness, sadness, loneliness, and alienation.

When one picks up a book of readings, the temptation is to skip around to those that seem the most interesting. It is difficult to make a choice when reading this book. The titles, for the most part, are catchy and invite interest. The section on philosophy is less involving and at times one feels that it is somewhat out of context with the rest of the book. It demands intense concentration and an interest in philosophical issues. At times, the reader wonders where the students' relatedness is, other than academic.

The real value of the book for educators would seem to be in understanding how their students are reacting to the stresses of life. The preface and foreword have content value for exploring the reasons for student feelings. Specifically, there is a review of material regarding the various life crises.

This is an excellent resource book and certainly an important addition to one's library. The book is not limited to any specific clinical area or nursing issue but is one nurses should be aequainted with in this day, for their own professional growth as well as their awareness of life situations.

Health Hazards of the Human Environment by the World Health Organization. 387 pages. Geneva, Switzerland, World Health Organization, 1972.

This book is concerned with the community environment, chemical contaminants and physical hazards, sur-

veillance and monitoring, and public health principles and practices of inter-The chapters are short, concise, and

full of information, including extensive bibliographic references. The material was prepared by 100 specialists from 15 countries, although the preface is careful to point out that not all those consulted agreed on each point!

The index makes possible the easy use of this book as a reference source. It will be a valuable addition to school

of nursing libraries.

Behavior and Illness, by Ruth Wu. 211 pages. Englewood Cliffs, N.J., Prentice-Hall, 1973.

Reviewed by Mary K. Harrison, Assistant Professor, McMaster University, School of Nursing, Hamilton, Ontario.

The author's stated purpose in this book is to "provide an understanding of the nature of illness." With this purpose she has defined nursing theory building to be part of her goal. However, those of us who see nursing as being more than illness oriented cannot agree with her focus. This is my major disagreement with this well-researched and well-integrated book. As a student of Rogers (Dr. Martha Rogers, Department of Nursing, New York University) and a thinking practitioner in community mental health, I cannot define nursing as does the author. I am interested in the steady state as well as the unstable one of man. I maintain that nursing's focus is man's whole experience, not just illness.

With this bias I am still impressed by the author's knowledge of sociology of illness. She critiques a variety of models and definitions from the literature, using her nursing model as a base. There is minimal input of interpersonal and/or psychoanalytic theory in the critique of the nursing model and those of "perceptions of illness" and of

"wellness.

The author integrates general system theory content into the chapter on the concept of stability. Some of the general system theoreticians could readily disagree with her definitions of homeostasis, which are based more on adaptative than general systems models.

The chapter on illness behavior offers some theoretical explanations of why siek people, so labeled, often do not behave as the medical professions and health educators would have them behave.

In summary, the author has presented an integrated review of the sociology of illness behaviors — illness, health, siek role, impaired (i.e., disabled) roles. As a stimulus to theoretical defi-

#### MOVING? **BEING MARRIED?**

Be sure to notify us six weeks in advance, otherwise you will likely miss copies.

> Attach the Label From Your Last Issue OR

Copy Address and Code Numbers From It Here

#### NEW (NAME) /ADDRESS:

Street City Zone

Please complete appropriate category:

I hold active membership in provincial nurses' assoc.

Zip

reg. no./perm. cert./ lic. no.

I am a Personal Subscriber.

MAIL TO:

Prov./State

The Canadian Nurse 50 The Driveway OTTAWA, Canada K2P 1E2

#### books

nition of nursing practice, it is a valuable part of the nursing literature integrating other sciences, both applied and pure. The book is a useful summary for students of patient behavior and a useful stimulus for theory building in nursing. As such, it is suitable for graduate (master's) students in nursing.

Anatomy & Physiology for Nurses, 8ed., by Katharine F. Armstrong and Sheila M. Jackson. 374 pages. London, Ballière Tindall, 1972.

Reviewed by Carmen Mitra, Assistant Professor, School of Nursing, University of Windsor, Windsor, Ontario.

This text is a handy reference for a beginning student. The logical sequence of presentation allows the reader to visualize the structures and arrangements, including their interrelated functions.

Chapter I gives a brief description of physics and chemistry that introduces the reader to the various substances and changes that might occur in the different processes to follow. Presentation of the chemistry portion of this chapter prepares the reader to understand chemical reactions that occur in the functioning of the systems as metabolism goes on.

Fluid and electrolyte balance is an important phenomenon in health and disease, but many students have found it difficult to understand. The fashion of presentation of this area stimulates interest and desire to continue the study. The examples of reactions leave a vivid picture in the mind so that students can use the knowledge in various

situations as they arise.

The second and third chapters deal with structure and characteristics of living matter. They present the process of cell division, genetics, and sex determination. Ribonucleic acid (RNA), deoxyribonucleic acid (DNA), and their roles in the propagation of species are mentioned briefly. This text can help the student better comprehend how the billions of microscopic cells comprise the human body, and how the different functions are carried out through action, reaction, and interaction

Different kinds of tissues with brief discussion of structure and functions of each, bones, and muscles are discussed. Composition, growth, and development of bones are discussed in fuller detail. With the rising rate of traffic accidents, the student will be better prepared to care for the victims if she understands the normal structures, arrangements and functioning of part or parts affected.

Blood and its components are discussed, including production and destruction of cells, an area that is becoming more and more important on account of voluminous factors that influence destruction of cells.

Blood transusion, a common form of therapy, can be better understood by the student after she has studied blood grouping and Rhesus factors.

Discussion on endocrine glands and diagramatic presentation of relationship of functions makes the subject more interesting and easier to follow.

However, the text should have given more discussion to the endocrine system, electrolyte and fluid balance, and the nervous system, which are more difficult to understand than the skeletal system.

The text can be useful for the beginning nursing student by virtue of the presentation in logical sequence, clear explanation of structures and their function.

With the current emphasis on an expanding role for the nurse in the provision of health service, the nurse will seek more and more knowledge in anatomy and physiology so that she can be more effective in recognizing deviations from normal. This book will be a good introduction to her search for more knowledge and understanding of the human body.

Peoplemaking by Virginia Satir. 304 pages. Palo Alto, Calif., Science & Behavior Books Inc., 1972.

Reviewed by Philip Gower, Former Assistant Director of Nursing Service, Queen Street Mental Health Centre, Toronto, Ontario.

Like pioneers in other fields, Virginia Satir has had the courage to produce an unusual manual; in this case, it is about the family, the "factory" that makes people. For nurses who are working with troubled families, this book on family therapy will prove extremely helpful. Techniques and "communication games" are introduced in such detail that they could be used by many families with a minimum of professional direction and help.

The author has observed that people have four basic patterns for handling interpersonal stress when self-esteem is involved. These patterns she labels "placating, blaming, computing, and distracting." During the communication games, which she invented herself, each pattern is used as a role that is

reallocated from one person to another. Combined with the familiar family roles of mother, father, child, and so forth, a number of interactions are arranged to allow various members of the family to see how the others actually act and feel. Thus, these "games" form the basis for an investigation, understanding, and treatment of a family's communication network.

The author has discovered that "... the minute people start to play the games, they know the dialogue." She comments: "For me this is a validation of the fact that my games reflect the actual experiences so many have had in their families and, as they grow up, in their society. Regardless of economic status, race, age, sex, nationality, or religion, everybody knows the communication games language."

Providing hope for families everywhere, the author states that "all of the ingredients in a family that count are changeable and correctable — individual self-worth, communication system, and rules — at any point in time." Each of these elements is explained in a complete chapter, cleverly illustrated with simple line drawings.

This book can help us become more efficient communicators, both within our own family structure and in our relationships with others in society. It is easy to use as a textbook, with separate chapters for communication theory, the communication games themselves, or other specific aspects of the family, such as couples or one-parent families.

Virginia Satir's warm concern to ease the pain she has encountered in her clinical work with families pervades the book: "I should probably pin medals on many of you for doing the best you know how with a difficult situation....It is my hope, however, that I can give you something more valuable than medals: namely, some new ways to find a better life together as a family."

#### accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, except reference items, may be borrowed by CNA members, schools of nursing and other institutions. Reference (R) items (archive books and directories, almanacs and similar basic books) do not go out on loan. Theses (also R) are on Reserve

(Continued on page 56)

# one step ahead

These Saunders texts can keep you ahead of the fast-paced advances in nursing care.

#### Watson: MEDICAL-SURGICAL NURSING AND RELATED PHYSIOLOGY

From "Causes and Effects of Disease" to "Nursing in Respiratory Disorders," the theme of this exceptional text is the physiological basis of effective treatment and care. The author's clear review of relevant anatomy, physiology and pathophysiology provides the nurse with an effective appreciation of measures and goals in medical-surgical nursing. Throughout, a concern for the patient's psychological, social, and economic well-being is demonstrated; practical information and guidance is provided so that the nurse may give effective total care. By Jeannette E. Watson, R.N., M.Sc.N. 786 pp. Illustd. \$10.30. April 1972.

#### Kolb: MODERN CLINICAL PSYCHIATRY **New Eighth Edition**

A standard in its specialty—complete descriptions of clinical conditions, reinforced by socio-medical background and current therapeutic measures. Chapters organized to conform to the new Eighth International Classification of Disease. Expanded material on disorders of infancy, childhood and adolescence; plus other new information on alcoholism, schizophrenia, psychophysiological disorders and drug dependence. Newly considered topics include general systems theory, poverty, racism, transsexualism and more. By Lawrence C. Kolb, M.D. 694 pp. \$13.40. January 1973.

#### Robinson: **PSYCHIATRIC NURSING AS A HUMAN EXPERIENCE**

Clinically oriented, this new book emphasizes the sympathetic one-to-one relationship between the psychiatric nurse and the patient—and its role in effective care. A wealth of information-principles and practical knowledge-makes up the content. Introductory chapters detail the role of the nurse in therapy and the relevant theoretical background: concepts of growth, the mental health-mental illness continuum, anxiety as a dynamic construct. Actual psychopathologies are discussed within a framework, social problems are analyzed, and psychiatric nursing in large universities is described. By Lisa Robinson, R.N., Ph.D. 35' pp. Sept. 1972. \$8.25.

#### Miller & Keane: **ENCYCLOPEDIA AND DICTIONARY OF** MEDICINE AND NURSING

The first, all-new nursing encyclopedia in 20 years—a comprehensive reference of accurate, up-to-date information. Clear-cut definitions fill more than 1000 pages. Full drug data is included. Special sections detail nursing care for most diseases, conditions, and operations-and first-aid instruction for such emergencies as burns, electric shock, and barbiturate poisoning. Contains 122 illustrations plus 16 pages of full-color plates. By Benjamin F. Miller, M.D. and Claire B. Keane, R.N., B.S. 1089 pp. 122 ills. + 16 tull-color plates. \$9.95. March 1972.

#### New 4th Edition Marlow: TEXTBOOK OF PEDIATRIC NURSING

A classic in the field of pediatric nursing, this text has been completely revised and rewritten to reflect up-to date concepts and methods in the care of children. It remains unexcelled in its comprehensive coverage of growth and development and nursing care needs of the sick and well child from birth through adolescence. Special attention has been given to genetics, current advances in patient care, government programs, research in fetology, ambulatory and home care, parenteral fluids, kwashiorkor, cystic fibrosis, scoliosis, acute epiglottis, Tay-Sachs and sickle cell diseases, contact dermatitis and much more. By Dorothy R. Marlow, R.N., Ed.D. 784 pp. 215 ills. About \$9.80. Just Ready.

W. B. SAUNDERS COMPANY CANADA, LTD. 833 Oxford Street, Toronto 18, Ontario	
Please send and	
☐ 9135 Watson: Medical-Surgical Nursing \$10.30. ☐ 7620 Robinson: Psychiatric Nursing \$8.25. ☐ 5486 Kolb: Clinical Psychiatry (8) \$13.40. ☐ 6355 Miller & Keane: Encyclopedia & Dictionary \$9.95. ☐ 6098 Marlow: Pediatric Nursing (4) About \$9.80.	
Name Address	
Prov	3

#### accession list

(Continued from page 54)

and may go out on Interlibrary loan only.

Request for loans should be made on the "Request Form for Accession List" and should be addressed to: The Library, Canadian Nurses' Association, 50 The Driveway, Ottawa, K2P 1E2.

No more than *three* titles should be requested at any one time.

#### BOOKS AND DOCUMENTS

- 1. Autotutorial techniques in nursing education, by Crystal M. Lange, Englewood Cliffs, N.J., Prentice-Hall, 1972, 105p.
- 2. Calgary General Hospital, 1890-1955; sixty-five years of community service. Calgary, Alberta, Calgary General Hospital, 1955, 57p.
- 3. Casebook in nursing education: student nurse problems, by Vivian Wood. London, Ont., Faculty of Nursing, University of Western Ontario, 1972. 301p.
- 4. The community and care-in-the-home services. Report of a survey. Ottawa, Ontario Association of Certified Visiting Homemakers, 1972. 149p.
- 5. Current drug handbook, 1972-74, by Mary

- W. Falconer et al. Toronto, Saunders, 1972. 250p.
- 6. Do it yourself revision for nurses, by E.J. Hull and B.J. Isaacs. London, Baillière Tindall and Cassell, 1970-1972. 6 vols.
- 7. Educating personnel for the allied health professions and services; administrative considerations. Edited by Edmund J. McTernan and Robert O. Hawkins. St. Louis, Mosby, 1972, 225p.
- 8. Educating tomorrow's doctors. Workshop papers prepared for World Conference on Medical Education, 4th, Copenhagen, 1972. New York, World Medical Association, Inc., 1972, 246p.
- 9. L'éducation sanitaire en matière de planification familiale; rapport d'un groupe d'étude de l'OMS. Genève, Organisation Mondiale de la Santé, 1971, 53p. (Its Série de rapports techniques no. 483)
- 10, Les examens de santé de masse. Genève,Organisation Mondiale de la Santé, 1972.104p. (Its Cahiers de santé publique no.45)
- 11. Faire l'amour, faire un enfant? fécondité et régulation des naissances. Ottawa, Seréna, 1972, 55p.
- 12. Food and civilization; a symposium. Washington, U.S. Information Agency, Charles C. Thomas, 1966, 308p. (Voice of America, Forum lectures)
- 13. Food, nutrition and diet therapy, by Marie V. Krause and Martha A. Hunscher. 5ed. Toronto, Saunders, 1972, 718p.
- 14. La gestion informatique, par Charles

Berthet et Wladimir Mercouroff, Paris, Presses Universitaires de France, 1972, 128p. (Que sais-je? no 1471)

15. Guide des hôpitaux en vue de l'agrément. Toronto, Conseil canadien d'Accréditation des Hôpitaux, 1972. 136p.

- 16. Key concepts for the study and practice of nursing, by Marjorie L. Byrne and Lida F. Thompson. St. Louis, Mosby, 1972, 101p. 17. Knowledge and society. Edited by Tal-
- 17. Knowledge and society. Edited by Talcott Parsons. Washington, U.S. Information Agency, 1968. 369p. (Voice of America. Forum lectures)
- 18. Manuel de l'aide-soignante, par P. Osenat. 2 éd. Paris, Masson, 1971, 443p.
- 19. Médicaments et solutions médicamenteuses; enseignement séquentiel préparatoire au diplôme d'infirmière, par Claire Brackman Keane et Sybil M. Fletcher. Montréal, HRW, en collaboration avec W.B. Saunders, 1972, 185p.
- 20. Our hospital, Anzac, British, Canadian. Pictures by Joyce Dennys; verses by Hampden Gordon & M.C. Tindall, 3ed. Toronto, S.B. Gundy, 191? I vol. R
- 21. Patient-nurse interaction; a study of patterns in acute psychiatric wards, by Annie T. Altschul Edinburgh, Churchill Livingstone, 1972. 235p. (Edinburgh, University Dept. of Nursing Studies, Monograph no.3)
- 22. Planning, providing, financing home and community health services; selected papers from Regional Meetings. New York, National League for Nursing, Dept. of Home Health Agencies and Community Health Services, 1972, 86p.
- 23. President's review and annual report, 1971. New York Rockefeller Foundation, 1971, 220p.
- 24. Proceedings of 1971 American Library Association Annual Conference. Chicago, 1972. 176p.
- 25. Public expectations and health care. Essays on the changing organization of health services, by David Mechanic. Toronto, Wiley, 1972. 314p.
- 26. The quality of man's environment; Smithsonian Institution Symposium, Feb. 16-18, 1967. Washington, U.S. Information Agency, 1969, 250p. (Voice of America. Forum lectures)
- 27. Report of Nursing Research Conference, 8th, Mar. 15-17, 1972. Albuquerque, N.M. New York, American Nurses Association, 1972. 326p.
- 28. Report, 1971. Toronto, Ontario Cancer Treatment and Research Foundation, 1972.
- 29. Report 1972. London, Royal College of Nursing and National Council of Nurses of the United Kingdom, 1972, 82p.
- 30. Report, 1971. Winnipeg, Sanatorium Board of Manitoba, 1971. 54p.
- 31. Standards of nursing care; a guide for evaluation, by Joan Haselman Carter et al. New York, Springer, 1972. 157p.
- 32. The supply of professional nurses and their recruitment and retention by hospitals; report, July 1971. K.A. Archibald. New York City, N.Y., Rand Inst., 1971. 95p.

33. The teen-ager's world. Washington, U.S.

**APRIL 1973** 

2130 WEST 12TH. AVE., VANCOUVER 9, B,C.

Information Agency, 1966. 284p. (Voice of America. Forum lectures)

34. The UCLA allied health profession projects; task inventories. Rev. Los Angeles, University of California, Division of Vocational Education, 1972. 247p.

#### PAMPHLETS

35. Current program policy and organization. New York, Milbank Memorial Fund, 1972. 19p.

36. Documentation - international code for the abbreviation of titles of periodicals. New York, American National Standards Institute, 1972, 4p. (ISO 4-1972 (E))

37. The dying person and the family, by Nancy Doyle. New York, Public Affairs Committee, 1972. 24p. (Public affairs pamphlet no. 485)

38. A guide to continuing nursing education in Alberta. Edmonton, University of Alberta, School of Nursing, 1972, 11p.

39. Homosexuality in our society, by Elizabeth Ogg. New York, Public Affairs Committee, 1972. 28p. (Public affairs pamphlet no. 484)

40. Induced abortion. A report of the meeting of the IPPF Panel of Experts on Abortion . . . 1971, and approved . . . 1972, Edited by R.L. Kleinman. London, International Planned Parenthood Federation, 1972. 38p.

41. Love, sex and birth control for the mentally retarded; a guide for parents, by Winnifred Kempton et al. 2ed., rev. Philadelphia, Pa., Planned Parenthood Assoc. of Southeastern Pennsylvania, 1971, 39p.

42. Nurse-patient census 1972. New York, National League for Nursing, 1972. 19p.

43. Policies, procedures, and criteria for approval of schools of nursing in British Columbia. Vancouver, B.C., Registered Nurses' Association of British Columbia, 1972, 31p.

44. Project of refresher course for nurses presented to the Department of Social Affairs. Montreal, Association of Nurses of the Province of Quebec, July 1971. 16p.

45. Report, 1971. London, King Edward's Hospital Fund for London, 1972. 27p.

46. Report, 1971/72. Ottawa, Canadian Council for International Cooperation, 1972. 16p.

47. A report on an emerging occupation: the physician's assistant, by Joel Kuritsky and Glenn Reeder. Los Angeles, University of California, Division of Vocational Education, 1971. 35p.

48. Room for improvement; a better environment for the mentally handicapped, by James Elliott, London, King Edward's Hospital Fund for London, 1972. 31p.

49. Top executives view health care issues, by Seymour Lusterman. New York, The Conference Board, 1972. 43p. (Conference Board report no. 552)

50. Wellesley World. Special commemorative issue, 60 years of service. Toronto, Wellesley Hospital, 1972, 20p.

51. What an occupational health nurse can do for you and your employees. New York, American Assoc. of Industrial Nurses, 1972,

GOVERNMENT DOCUMENTS Canada

52. Bureau Fédéral de la Statistique. Grades, diplômes, certificats décernés par les universités et collèges 1969/70. Ottawa, Information Canada, 1971. 91p.

53. Commission d'assurance-chômage. Rapport, 1971. Ottawa, Information Canada, 1972, 18p.

54. Conseil des sciences du Canada. In vivo -quelques lignes directrices pour la biologie fondamentale an Canada. Ottawa, Information Canada, 1972, 79p. (Its Rapport no. 17) 55. Conseil économique du Canada. Coût, production et productivité des universités canadiennes, par Walter Hettich. Ottawa, Information Canada, 1972. 101p. (Its Etude spéciale no. 14)

56 .- Les coûts et l'efficacité dans les hôpitaux canadiens, par R.D. Fraser. Ottawa, Information Canada, 1972. 157p. (Its Etude spéciale no. 13)

57.—. Nouvelles voies de prise de décisions publiques, par Alice M. Rivlin. Ottawa, Information Canada, 1972. 43p. (Its Etude spéciale no. 18)

58. Dept. of Finance. Economic review; a general review of recent economic developments, 1971. Ottawa, Information Canada, 1972. 172p.

59. Dept. of Indian Affairs and Northern Development. Canada's north, 1970-1980. Statement of the Government of Canada on Northern Development in the 70's. Ottawa, Information Canada, 1972. 40p.

60 .- . The melting snowman; the Canadian Indian Residence as a place for children to live and grow, by Hilary J.M. Fulton. Ottawa, 1972. 84p.

61. Dept. of Manpower and Immigration. Report 1970/71. Ottawa, Information Canada, 1971. 27p.

62. Dept. of National Health and Welfare. Family Planning Division. Family planning resource guide. Ottawa, 1972. 64p.

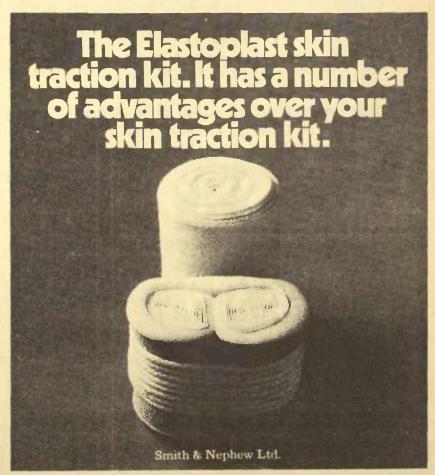
63.—. Health Manpower Planning Division, Canada health manpower inventory 1972. Ottawa, 1972. 130p.

64. Dept. of Public Works. Bilingual glossary of terms and expressions used in the office. Ottawa, Information Canada, 1972.

65. Dominion Bureau of Statistics. Degrees, diplomas, certificates awarded by degreegranting institutions, 1969f70. Ottawa, Information Canada, 1971, 89p.

66 .- Health and Welfare Division. Mental Health Section. Manual for the classification of psychiatric diagnoses. Based on the International Classification of Diseases, Adapted, (ICDA-8), Ottawa, Queen's Printer, 1969, 92p.

67. Economic Council of Canada, Search behaviour in Canadian job markets, by Dennis R. Maki. Ottawa, Information Canada, 1972. 98p. (Its Special study no. 15)



#### accession list

68. Minister of National Health and Welfare. Annual report respecting operation of the Medical Care Act, 1971. Ottawa, Information Canada, 1972, 18p.

69. Ministère des finances. Compte rendu de la situation économique, 1971. Ottawa. Information Canada, 1972, 178p.

70. Ministère du Revenu national accise. Liste des hôpitaux publics certifiés: noms et adresses des hôpitaux publics certifiés aux fins de la loi sur la taxe d'accise. Ottawa, Information Canada, 1972, 1 vol.

71. National Library of Canada, Report, 1971/72. Ottawa, Information Canada, 1972.

72.— Research and Planning Branch, Canadian national union catalogue; location requests survey. Ottawa, 1972, 88p.

73. Public Service Commission. Report, 1971. Ottawa, Information Canada, 1972. 56p.

74. Royal Commission on Bilingualism and Biculturalism. Ethnic relations in Canadian voluntary association, by John Meisel. Ottawa, Information Canada, 1972. 354p. (Its Documents no. 13)

74. Science Council of Canada. Air quality

local, regional, and global aspects, by R.E. Munn. Ottawa, Information Canada, 1972. 39p. (Its Special study no. 24)

76.—. It is not too late—yet: a look at some pollution problems in Canada's natural environment; an identification of some major concerns, Ottawa, Information Canada 1972. 49p. (Its Report no. 16)

77.—. Lifelines: some policies for basic biology in Canada. Ottawa, Information Canada, 1972. 73p. (Its Report no. 17)

78.—. Policy objectives for basic research in Canada, Ottawa, Information Canada, 1972. 75p. (Its Report no. 18)

79. Statistics Canada. Census of Canada 1971, special bulletin: population, specified mother tongues for census divisions and subdivisions. Ottawa, 1972. 97p. (Catalogue no. 92-773 (SP-3))

80. Statistics Canada, Degrees, diplomas, certificates awarded by degree-granting institutions, 1970/71. Ottawa, Information Canada, 1972, 85p.

81.—. Surgical procedures and treatment, 1969. Ottawa, Information Canada, 1972.

82.—. Labour Division. Facts about the unemployed, 1960-1971. Ottawa, Information Canada, 1971, 48p. Ontario

83. Ministry of Health. An implementation for the new orientation and structure of the Ministry of Health. Toronto, 1972. 28p.

84. Ministry of Labour. Research and Planning Branch. The compressed work week in Onturio, Toronto, 1972. 12p.

85. Health Insurance Board. Report, 1971f 72. Quebec, 1972. 46p.

United States

86. Congress. House. Committee on Ways and Means. Basic facts on the health industry, June 28, 1971. Washington, U.S. Govt. Print. Off., 1971, 141p.

87. Dept. of Health, Education and Welfare. National Institutes of Health. Nurse practitioners. Bethesda, Md., 1972. 15p. (Its Portfolio series no. 4)

88. National Institutes of Health, Division of Nursing. From student to RN; a report of the nurse career-pattern study by Lucille Knopf. Bethesda, Md., 1972. 154p. (U.S. DHEW Publication no. (N1H) 72-130)

STUDIES DEPOSITED IN CNA REPOSITORY COLLECTION

89. A report on implications for family life education in Saskatchewan, by Marie Kishchuk. Saskatoon, Sask., Extension Division, University of Saskatchewan, 1972, 11p. R

90. A study of varying admission requirements to twelve Alberta schools of nursing using a common external criterion after three years of nursing education, by Donald B. Black and Ruth E. McClure. Edmonton, University of Alberta, 1972. 12p. R

## Request Form for "Accession List" CANADIAN NURSES' ASSOCIATION LIBRARY

Send th	his coupon or facsimile to:	
	AN, Canadian Nurses' Association, 50 The Driveway, lend me the following publications, listed in the	
Canadia	an Nurse, or add my name to the waiting list to re	ceive them when available:
Item No.	Author	Short title (for identification)
**********		
	sts for loans will be filled in order of receipt. nce and restricted material must be used in the	e CNA library.
Borrowe	er	Registration No
D == 141 ==		

Date of request ......

Address

## DO YOU WANT TO HELP YOUR PROFESSION?

Then fill out and send in the form below

### REMITTANCE FORM CANADIAN NURSES' FOUNDATION

50 The Driveway, Ottawa K2P 1E2, Ontario

A contribution of \$..... payable to the Canadian Nurses' Foundation is enclosed and is to be applied as indicated below:

#### MEMBERSHIP (payable annually)

Nurse Member —	Regular	\$ 5.00
	Sustaining	\$ 50.00
	Patron	\$500.00
Public Member —	Sustaining	\$ 50.00
	Patron	\$500.00
SURSARIES \$	RESEAR	CH \$
MEMORIAL \$	in memory of	
•••••		

Name and address of person to be notified of this gift .....

Address Position .....

(Print name in full)

Employer .....

N.B.: CONTRIBUTIONS TO CNF ARE DEDUCTIBLE FOR INCOME TAX PURPOSES

# Index **Advertisers April 1973**

Abbott Laboratories
Astra Pharmaceuticals
Baxter Laboratories of Canada Limited
Davol Inc
General Time of Canada Limited Cover IV
Hollister Limited
Frank W. Horner Ltd
ICN Canada Ltd
J.B. Lippincott Company of Canada Ltd 1
McGraw-Hill Ryerson Limited 8
C.V. Mosby Company, Ltd 16, 17
Octo Laboratory Ltd
Organon Canada Ltd Cover 111
Perry Rubber Company
J.T. Posey Company 5
Procter & Gamble
Reeves Company
W.B. Saunders Company Canada, Ltd 55
Smith & Nephew Ltd 57
White Sister Uniform, Inc
Wyeth Limited

Advertising Manager Georgina Clarke The Canadian Nurse 50 The Driveway Ottawa K2P 1E2 (Ontario)

Advertising Representatives Richard P. Wilson 219 East Lancaster Avenue Ardmore, Penna, 19003

Vanco Publications. 2 Tremont Crescent Don Mills, Ontario

Member of Canadian Circulations Audit Board Inc.

ccab

#### **PROVINCIAL ASSOCIATIONS OF REGISTERED NURSES**

#### Alberta

Alberta Association of Registered Nurses, 10256—112 Street, Edmonton. Alberta. T5K 1M6.

Pres.: R. Erickson; Pres.-Elect: A.J. Prowse; Vice-Pres.: D.E. Huffman, A. Thompson. Committees — Staff Nurses: C. Asp.: Nsg. Educ.: D. Aune; Nsg. Practice: K. Masson; Superv. Nurses: P. Hartrick; Project Direc. Nsg. Educ.: M. Moncrieff; Prov. Office Staff — Pub. Rel.: R.R. Donahue; Employ. Rel.: Y. Chapman; Nsg. Serv. Consult.: B. Sellers; Comm. Advisor: H. Cotter; Registrar: D.J. Price; Exec. Sec.: H.M. Sabin; Office Manager: M. Garrick.

#### **British Columbia**

Registered Nurses' Association of British Columbia, 2130 West 12th Ave., Vancouver 9, British Columbia.

Pres.: M. Neylan; Vice-Pres.: G. LaPointe. D. Ranson. Committees — Nsg. Educ.: J.K. Griffith; Nsg. Practice: E.H. Dancer; Soc. & Econ. Welf.: B. Archer. Staff — Exec. Direc.: F.A. Kennedy; Registrar: H. Grice; Direc. Educ. Serv.: F.C. Tissington; Asst. Direc. Educ. Serv.: P. Cutshall; Direc. Nsg. Serv.: T. Schnurr; Direc. Personnel Serv.: N. Paton; Asst. Direc. Personnel Serv.: F. MacDonald; Direc. Comm. Serv.: C. Marcus; Librarian: J. Molson

#### Manitoha

Manitoba Association of Registered Nurses, 647 Broadway Avenue, Winnipeg 1, Manitoba, R3C OX2.

Pres.: F. McNaught; Pust Pres.: E.M. Nugent; Vice Pres.: R.G. Black, M. Mackling. Committees — Nsg. Serv.: A. Croteau; Nsg. Educ.: M. Swedish; Soc. & Econ. Welf.: A. Daniels; Legisl.: O. McDermott; Brd. of Examiners: O. McDermott; Finance: M. Fluegel; Employ. Rel. Officer; J. Gleason; Pub. Rel. Officer; M. Paynter; Registrar: M. Cadwell; Exec. Direc.: Sr. T. Carignan; Coord, Contin. Educ.: H. Sundstrom.

#### **New Brunswick**

New Brunswick Association of Registered Nurses, 231 Saunders Street, Fredericton, New Brunswick.

Pres.: A. Robichaud; Pust Pres.: H. Hayes; 1st Vice-Pres.: B. LeBlanc; 2nd Vice-Pres.: S. Cormier; Hon. Sec.: Sr. S. Robichaud. Committees — Nsg. Educ.: C. Peplar; Nsg. Serv.: Z. Hawkes; Nsg. Asst. Comm.: J. Sherwood; Finance: B. LeBlanc; Legisl.: K. Wright; Exec. Sec.: M.J. Anderson; Liaison Officer: N. Rideout; Consult. Soc. & Econ. Welf.: G. Rowsell; Registrar: E. O'Connor; Asst. Exec. Sec. & Registrar: M. Russell; Educ. Consult.: A. Christie.

#### Newfoundland

Association of Nurses of Newfoundland, 67 Le Marchand Road, St. John's, Nfld.

Pres.: E. Wilton: Past Pres.: P. Barrett; Pres.: Elect: F. Bouzan; Ist Vice Pres.: E. Summers; 2nd Vice Pres.: J. Nevitt, Committee Nsg. Educ.: E. Gardner; Nsg. Serv.. J. Pawlett; Soc. & Econ. Welf.: W. Williams: Exec. Sec.: P. Laracy.

#### Nova Scotia

Registered Nurses' Association of Nova Scotia, 6035 Coburg Road, Halifax, N.S. Pres.: M. Bradley; Pust Pres.: J. Fox; Vice-Pres.: Sr. M. Barbara, G. Smith, C. Butler; Advisor Nsg. Educ.: Sr. C. Marie; Advisor Nsg. Serv.: J. MacLean. Committees — Nsg. Educ.: T. Blaikie; Nsg. Serv.: S. MacDonald; Soc. & Econ. Welf.: G. Murphy; Exec. Sec.: F. Moss; Employ. Rel. Officer: M. Bentley; Pub. Rel. Officer: D. Miller.

#### Ontario

Registered Nurses' Association of Ontario, 33 Price Street, Toronto M4W 1Z2. Ontario. Pres.: M.J. Flaherty; Pres. Elect: W. Gerhard. Committees—Socio-Econ. Welf.: C.P. Seppala; Nsg.: G.L. Schmidt; Educator: C.J. Faulkner; Exec. Direc.: L. Barr; Asst. Exec. Direc.: D. Gibney; Direc. Employ. Rel.: A.S. Gribben; Direc. Profess. Develop.: C.M. Adams; Reg. Exec. Sec.: M.I. Thomas. F. Winchester.

#### Prince Edward Island

Association of Nurses of Prince Edward Island, 188 Prince Street, Charlottetown. Pres.: E. MacLeod; Past Pres.: C. Carruthers; Pres. Elect: B. Robinson; Vice Pres.: S. Mulligan; Exec. Sec. Reg.: L. Fraser. Committees — Nsg. Educ.: B. Mair; Nsg. Serv.: M. Vessey; Pub. Rel.: H. Wood; Finunce: C. Carruthers; Legisl. & By-Laws; Sr. M. Cahill; Soc. & Econ. Welf.: F. Reese.

#### Quebec

Association of Nurses of the Province of Quebec, 4200 Dorchester Blvd., W., Montreal, Quebec.

Pres.: R. Bureau; Vice Pres.: S. O'Neill, G. Lennox, (Eng.), J. Tellier-Cormier, E. Foy, (Fr.); Hon. Treas.: Sr. P. Lecours; Hon. Sec.: R. Coutts. Committees Nsg. Educ.: G. Allen, D. Lalancette: Nsg. Serv.: J. Hackwell, R. Dionne; Professional Serv.: S. O'Neill, P. Murphy; School of Nsg.: M. Barrett, C. de Villiers Sauvé; Legisl.: M. Masters. Sec. Reg.: N. DuMouchel; Pub. Rel. Officer: M. Jean.

#### Saskatchewan

Saskatchewan Registered Nurses' Association, 2066 Retallack St., Regina, Sask. S4T 2K2.

Pres.: D.J. Pipher; Past Pres.: E. Linnell; Pres. Elect: B. Rushton; Ist Vice Pres.: J. Innis; 2nd Vice Pres.: S. Rhoden. Committees—Nsg. Educ.: I. Watson; Chapters & Pub. Rel.: Sr. B. Bezaire; Soc. & Econ. Welf.: M.A. Dibin; Exec. Sec.: A. Mills; Registrar: E. Dumas; Employ. Rel. Officer: A.W. Shalansky; Pub. Rel. Officer: B. Schill; Nsg. Consult.: R. Walker; Asst. Registrar: J. Passmore.



#### Canadian Nurses' Association

#### Directors

#### **National Office**

Executive

Director	Helen K.	Mussallem
Associate Exec	cutive Directo	or
	Jane	Henderson
General		
Manager	Frnest \	Van Raalte

SRNA ...... D.J. Pipher

Research a	nd Advis	ory Servi	ices
Nursing			
Coordina	tor H	larriett J.	T. Sloan
Research O	fficers	. Sister M	adeleine
Bachand,	Nancy	Garrett,	Rachel
Lamothe			
Library	M	largaret L	Parkin

#### Information Services

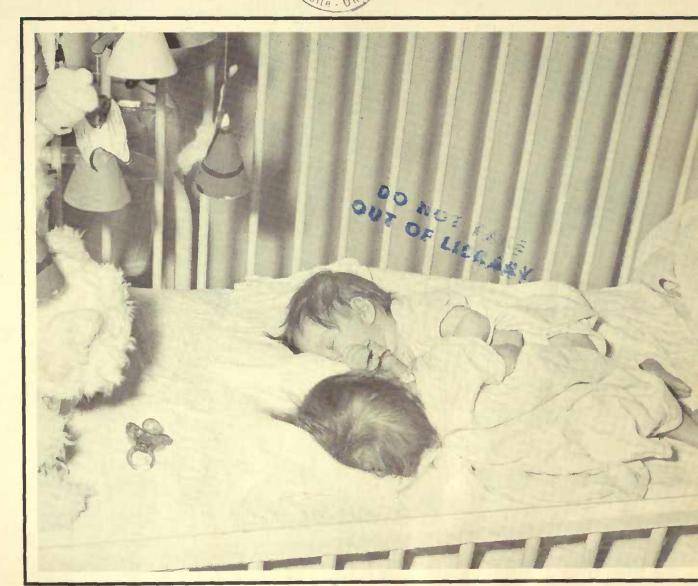
Editor, The Canadian		
Nurse Virginia	A.	Lindabury
Editor, L'infirmière		

canadienne ......Claire Bigué

# The Canadian Nursing Nursing

May 1973

OUT OF LIPDARY



conjoined twins

how CNF scholars are selected





Our beautiful "Royale Supreme" Polyester blended with Nylon fabric exquisitely styled by the Career Dress. Division of White Sister Uniform Inc.



A LABEL YOU SHOULD LOOK FOR AT YOUR FAVOURITE UNIFORM SHOP

FOR EXCEPTIONAL VALUE

A) STYLE		0940	
	SIZE	10 - 20	
auahla	PRICE ABOUT	\$11.08	

B) STYLE 40908 SIZE 5 - 15 Unbelievable PRICE ABOUT \$10.98

C) STYLE 40906 SIZE 5 - 15

Inbelievable PRICE ABOUT \$10.98





SERVING THE HEALTH PROFESSIONS IN CANADA SINCE 1897

#### MATERNAL CHILD NURSING

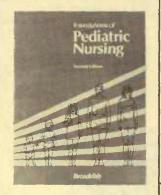
#### **NEW EDITION**

#### **FOUNDATIONS OF** PEDIATRIC NURSING **Second Edition**

Violet Broadribb, R.N., M.S.

The author, an experienced nurse clinician, has broadened and enriched the second edition to reflect new nursing concepts stemming from recent findings in child psychology as well as advances in pediatric medicine and surgery. New or expanded material includes psychosocial development, genetic factors, the child as member of a family unit, care of the newborn in the intensive care unit, pediatric

pharmacology.
As in the first edition, material is presented according to age groups from birth to adolescence. The Appendix contains preparations for laboratory tests, common pediatric procedures, and a section on pediatric drugs, dosages, actions and



#### MATERNITY NURSING Twelfth Edition

Elise Fitzpatrick, R.N., M.A.

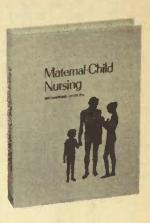
This family-focused book is directed toward the total health and well-being of the mother and infant. Expanded and updated in line with new medical concepts and concomitant nursing practice, this is comprehensive maternity nursing at its best.

The importance of psychosocial factors is reflected in the authors' decision to integrate psychological principles throughout the text and add an entirely new chapter on Social Factors. New chapters also include Patient Teaching and Fetal Diagnosis and Treatment.

#### MATERNAL-CHILD NURSING

Violet Broadribb, R.N., M.S. and Charlotte Corliss, R.N., M.Ed. A family-centered text, developed by the authors for combined maternal child nursing courses wherein students are being prepared to give direct care to mothers and children. The first half of the text covers the entire maternity experience, labor and delivery as well as and postpartum care. Current information on homemaker service, family planning clinics and parent education is included in the chapter on "Community Resources Available to the Family." Units Five to Twelve deal with child care from birth to adolescence. Delinquency, drug abuse, and similar problems are con-sidered in discussion of the

#### NEW!



#### **EMOTIONAL CARE OF HOSPITALIZED CHILDREN** An Environmental Approach Madeline Petrillo, R.N., M.Ed.

often difficult family adjustment

of the older child.

This text is an outgrowth of the dedicated effort by a group of experienced clinicians to reduce the trauma in children, as well as parents, brought about by illnesses requiring hospitalization. Preventive approaches to minimizing trauma are supported by an analysis of actual clinical situations. For nurses and other personnel who have a part in the clinical management of children, or are involved in any way in the health care milieu, this text is a breakthrough in bridging the gap between understanding and action.

#### NURSING CARE OF CHILDREN **Eighth Edition**

Florence G. Blake, R.N., M.A.

Completely revised and expanded, with a new format and many new illustrations, this superb text is without peer as a comprehensive, in-depth study of pediatric nursing. It is organized according to age groups, from infancy to adolescence. Increased emphasis is placed on growth and development at each age period.



J. B. Lippincott Company of Canada Ltd. 75 Horner Ave. Toronto, Ont. M8Z 4X7

Representing in Canada: Little, Brown & Company Blackwell Scientific Publications Ltd. Springer Publishing Company, Inc.

FDUNDATIONS OF PEDIATRIC NURSING  MATERNITY NURSING	flexible cover \$ 7.95 cloth \$ 9.95 cloth \$10.95
MATERNAL-CHILD NURSING	cloth \$10.50
EMOTIONAL CARE OF HOSPITALIZED CHILDREN	flexible cover \$ 5.75 cloth \$ 8.00
NURSING CARE OF CHILDREN	cloth \$10.50
Please send me the books I have checked	
Name	Position
Address	
City	Province
Payment enclosed, ship prepaid	Use my Chargex no
Books may be returned within 15 days	CN5-73

# for relief of postpartum discomforts only Tucks babies tender tissues two ways

as a soothing wipe...as a cooling compress...and as often as she likes

Tucks medicated pads give your postpartum patient more relief, more often than ointments or aerosols because pads can be used more ways. Cooling Tucks medication can be applied by using the pad as a compress. Or the pad can be used as a wipe to both soothe and cleanse. As a wipe, it lets her avoid the mechanical irritation of harsh, dry toilet paper, A Tucks pad under her sanitary pad prevents chafing too.

Tucks medication gives prompt, temporary relief from postpartum discomforts—the Itching, burning and irritation of episiotomies and simple hemorrhoids, its active ingredients are witch hazel and glycerine-there is no "caine" type anesthetic in it. Your patient can have her own supply of Tucks at bedside for self-administered relief with minimum risk of over-treatment or sensitization.

In addition, Tucks medication is buffered to an approximate pH of 4.6. This helps tissues maintain their normal acid defenses. Prescribe Tucks pads at bedside for soothing, cooling comfort from the first postpartum day on.

Order a trial supply on your Rx. Write to:

675 Montée de Liesse Montréal 377, Oueber



# The Canadian Nurse



A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 69, Number 5

May 1973

- 23 The Expanded Role of the Nurse: A Joint Statement of CNA/CMA
- 33 How CNF Scholars Are Selected ...... J. Henderson, B. Archibald
- 39 What Will Happen to Mr. Lang? ..... L. Horton

The views expressed in the editorial and various articles are those of the authors and do not necessarily represent the policies or views of the Canadian Nurses' Association.

4 Letters

47 Names

9 News

48 Books

44 Dates

- 50 AV Aids
- 45 New Products
- 51 Accession List

Executive Director: Helen K. Mussallem • Editor: Virginia A. Lindabury • Assistant Editors: Liv-Ellen Lockeberg, Dorothy S. Starr • Editorial Assistant: Carol A. Dworkin • Production Assistant: Elizabeth A. Stanton • Circulation Manager: Beryl Darling • Advertising Manager: Georgina Clarke • Subscription Rates: Canada: one year, \$6.00; two years, \$11.00. Foreign: one year, \$6.50; two years, \$12.00. Single copies: .75 cents each. Make cheques or money orders payable to the Canadian Nurses' Association. • Change of Address: Six weeks' notice; the old address as well as the new are necessary, together with registration number in a provincial nurses' association, where applicable. Not responsible for journals lost in mail due to errors in address.

Manuscript Information: "The Canadian Nurse" welcomes unsolicited articles. All manuscripts should be typed, double-spaced, on one side of unruled paper leaving wide margins. Manuscripts are accepted for review for exclusive publication. The editor reserves the right to make the usual editorial changes. Photographs (glossy prints) and graphs and diagrams (drawn in india ink on white paper) are welcomed with such articles. The editor is not committed to publish all articles sent, nor to indicate definite dates of publication.

Postage paid in cash at third class rate MONTREAL, P.O. Permit No. 10,001. 50 The Driveway, Ottawa, Ontario. K2P 1E2

Canadian Nurses' Association 1973.

About five years ago, there were rumblings across the country about the introduction of the physicians' assistant - a new category of health worker who would bridge "the professional gap" between nursing and medicine. In an editorial in the January 1969 issue, I wrote about this subject, strongly opposing the creation of a new category of health worker (or "a new breed of cats," as one physician put it). What was needed, I said, was more dialogue between the medical and nursing professions to find other ways of filling any present "gap."

In October 1970, the Canadian Nurses' Association took a stand against the introduction of the physicians' assistant, stating it believed the health needs of the Canadian people could more effectively and economically be served by expanding the role of the nurse. CNA also said that experimentation with various patterns of health care, using the nurse in an extended and more independent role, was urgently needed, and stressed the importance of proceeding jointly with the

medical profession.

Much has happened since 1969, when it seemed quite possible that a physicians' assistant role would be introduced. For example, "experimentation with various patterns of health care," using the nurse in an expanded role, has been undertaken; conferences have been held to discuss health manpower needs; and nurses and doctors have sat on panels to express their beliefs on how patients' needs can best be met. In other words, communication among members of the two professions has improved and increased.

As further evidence of this desire to work together, CNA and CMA set up a joint committee last year to study the expanded role of the nurse. This committee's report (p.23) has been accepted, with some modifications, by the directors of both associations.

The highlight of the report is this: Both associations agree that health services can be more effective by expanding the role of the nurse, rather than by creating a new category of worker.

—V.A.L.

## letters

Letters to the editor are welcome.

Only signed letters, which include the writer's complete address, will be considered for publication.

Name will be withheld at the writer's request.

Reprints of article available

The March Canadian Nurse arrived in our division this morning, and requests are already coming in for reprints of Dr. Spitzer's useful article, "Ten Tips for Preparing Research Proposals." Will these be available? — Shirley M. Stinson, RN, Ed.D., professor and senior national health scientist, division of health services administration, University of Alberta, Edmonton.

Reprints of Dr. Spitzer's article are available. Write to the Editor, The Canadian Nurse, for information recost.

I would like to congratulate *The Canadian Nurse* for publishing W.O. Spitzer's article, "Ten Tips on Preparing Research Proposals" (March 1973). The article will be useful to our school of nursing faculty.

I hope this article represents the beginning of a series devoted to research in nursing or to nurses and research.

— Helen Niskala, R.N., M.S., coordinator, basic degree program, The University of Alberta School of Nursing, Edmonton, Alberta.

Concerned by letter

It was with some concern that I read Ms. Barter's letter to the editor in the March 1973 issue. In it she critized Ms. Peitchinis' review of a Canadian text, Medical-Surgical Nursing and Related Physiology, stating that nursing experts in the United States selected this as a most significant book in its area of practice. She also suggested that The Canadian Nurse give merited recognition and encouragement to Canadian contributors to the nursing literature.

My concerns are twofold. First, despite the fact that Ms. Peitchinis, presumably a Canadian nursing expert, deemed the book to be limited in certain areas for our purposes, it seems that Ms. Barter still insists we give it recognition, since it is a Canadian publication. This seems to me to be illogical. I certainly see no sense in misleading readers into purchasing a book simply because it is a Canadian publication, only to find later it is of little use to them.

Second, if the U.S. nursing experts find a book useful to them, does it necessarily follow that it will suit the

needs of Canadians as well? Is it not time that we began to use our own resources in Canada, instead of turning to our sisters to the south for guidance?

It appears we have begun to establish our own priorities and evolve our own philosophics of nursing. Heaven forbid that we take a step backward and look to the Americans to determine what is best for us. At least it seems that Ms. Peitchinis has broken away from the old follow-the-leader type thinking. I hope that more of us can learn to do it — soon. — Pamela Khan, M.Sc.(A), Montreal, Quebec.

News headline misleading

The executive of the Association of Nursing Directors and Supervisors of Ontario Official Health Agencies (A.N. D.S.O.O.H.A.) has requested that I draw your attention to the headline that appeared with a news story in the November 1972 issue (page 16).

The news report was accurate in stating the content of the briefs to the minister of health of Ontario, However, the headline might indicate that A.N.D. S.O.O.H.A. has recommended that the appointees to the district health councils and to a placement in the new structure of the ministry of health be public health nurses.

We wish to correct any misinterpretation. Our intent is that the nurse appointed to function in these areas be representative of all Ontario nurses.

A.N.D.S.O.O.H.A. executive members are presently meeting with representatives from various fields of nursing and with representatives from the Registered Nurses' Association of Ontario to discuss the proposals in the brief.

Messages supporting the briefs have been sent by the nursing section of the Ontario Public Health Association to the minister of health and the nursing disciplines to which the briefs had been sent. — Patricia Perrault, President, Association of Nursing Directors and Supervisors of Ontario Official Health Agencies, Bracebridge, Ontario.

Coronary nurses describe program

In response to the article "Coronary Patients and Their Families Receive Incomplete Care" by Joan Royle in the February 1973 issue, we wish to inform readers of the existence of our coronary patient educational program at the Royal Jubilee Hospital in Victoria, British Columbia.

In recognition of the need for rehabilitative postcoronary education for patients and families, a formal program of instruction was developed in 1970 under the direction of Dr. G.M. Woodwark, as part of a research project funded by the B.C. Heart Foundation.

Through the use of in-hospital and home teaching, the program appears to help reduce the incidence of recurrence of myocardial infarction and the number and severity of postinfarction complications. Myths regarding heart disease are being eliminated through increased patient and family knowledge.

Research funding still covers a large part of the program, such as home visits for the experimental group. We hope we can demonstrate the essential nature of patient teaching of this kind as an integral part of nursing care, and hope this factor will be recognized in staffing budgets.

Nursing staff, patients, and families have responded enthusiastically to this program. — Mary Inkster, administrative supervisor, coronary and telemetry units, and the coronary nurses, Royal Jubilee Hospital, Victoria, B.C.

**Excellent article** 

"Whose baby is this?" (March 1973) was an excellent article. Ms. Baizley has said all the things that we, as nurses, should believe in and practice. The nurses' communication with the parents sounds terrific. — Joan Ginmell, Reg.N., Flin Flon, Manitoba.

**Compares Canada and Philippines** 

I have some comments to make regarding professional nursing practice in Canada and the Philippines. I have been in North America 13 years, have lived in Canada 9 years, and have practiced nursing in 7 hospitals across Canada

In this country I have found that the responsibility between a certified nursing assistant and a staff nurse is not well defined. Further, the nursing profession does not encourage a nurse to use her brains; rather, she is allowed to do only routine ward work, which

anyone can do without taking the basic nursing curriculum. Nursing administrators and educators should realize that a responsible RN should at least be able to use her educational back-

ground.

I have worked with nurses from about 72 countries under the foreign exchange program in the United States. I know Canadian nurses are the best and are well liked, but unfortunately nursing in Canada is not at a professional level. To me, nursing means continuous learning while I take care of and manage a patient. I cannot find this in general duty nursing in Canada.

Nursing in the Philippines taught me what it means to be a professional nurse, especially in community work. In the Philippines, either you do hospital nursing or community nursing; you are allowed to practice what you learned in the three-year diploma program. A nursing assistant or any paramedical worker in the hospital has to follow the RN's instructions for the nursing management of the patient. An RN does not do the same work as a certified nursing assistant.

A nurse can do a great deal if she is allowed to work to her capacity as a professional RN, helping the patient not only with physical routine care, but also with other needs relating to his home and community. - Lourdes Heber, RN, Dartmouth, Nova Scotia.

Homecoming year in '74

All graduates of Victoria Public Hospital School of Nursing in Fredericton, New Brunswick, are invited to a phasing out reunion in 1974 — a homecoming year.

Any graduates who have not received information about this should contact Lois Clark, 358 Brunswick Street, Fredericton. — Joanne MacPherson, Corresponding Secretary, Alumnae Association.

Change in policy at U of T

I believe the following information will be of interest to a number of nurses.

A change in policy was recently approved by the school of graduate studies of the University of Toronto regarding part-time study in the graduate course in nursing. Previously, students who enrolled in the master's degree course were required to register for a minimum of 16 months' full-time study.

According to the revision, a candidate may complete the work of one academic year as a part-time student if he receives the recommendation of the graduate department of nursing and the approval of the school of graduate

studies. **MAY 1973** 

All requirements for the degree must be completed satisfactorily within four calendar years from the date of the student's first enrollment in the program leading to the degree of master of science in nursing. — Jeannette E. Watson, acting chairman and academic secretary, graduate department of nursing, University of Toronto.

Nurses should share experience

Professional renewal is essential if nursing is to fulfill its aim of promoting optimal health. In university schools of nursing, there is ferment, change, and growth. Undergraduates, postgraduates, and faculty are excited and challenged at being in on the exhilarating process of education.

However, many nurses are cut off from day-to-day sharing in this process. These are the general duty staff nurses, whose load is considerable. As they deal with disease, human frailty, and bureaucratic bumbling, it is easy for them to get into a frame of mind where concern with their own problems takes precedence over patient care.

When students learned on the job, hospital staff shared in the teaching and were part of the professional growth process. We cannot turn back the clock; broader nursing education is here to stay. But we should look critically at the effects it has had.

The creative function of the hospital nurse — teaching students — is dying, if not dead. The strongest instincts in any individual or group are those of survival and reproduction. Nurses are surviving, but many are denied their share of helping to shape the next generation. In divorcing education from service, we have removed a potent force for professional renewal.

Unlike teachers, nurses do not have long vacations when they can upgrade their qualifications. Neither can they declare a nurses' convention, close the hospitals, and have a few days of study and consultation. The problem of education and renewal for general duty staff needs to be looked at.

I believe nurses would benefit from sharing their experience by teaching students from academic programs. They could teach either in short periods during the university year or in a period of internship at the end of their studies. It is said that beginning degree graduates lack confidence in practical areas, whereas they are strong in problem-solving. Surely the profession would benefit, especially in lowered hostility between diploma and degree members, if these nurses intermingled and if the strengths of both were fully used. — J.I.Johnston, Edmonton, Alberta.



This hand was bandaged in just 34 seconds with

Tubegauz

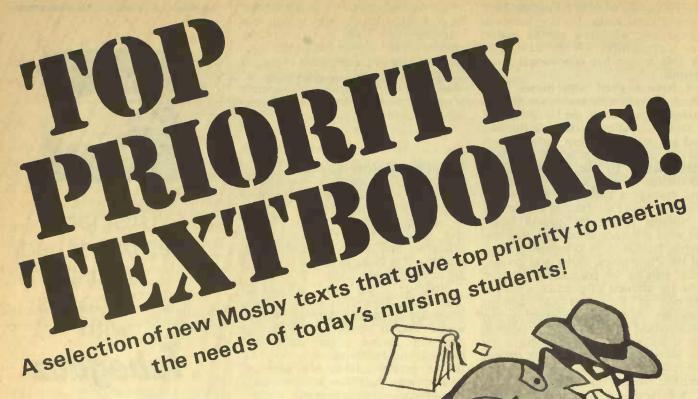
SEAMLESS TUBULAR **GAUZE** 

It would normally take over 2 minutes. But the Tubegauz method is 5 times faster-10 times faster on some bandaging jobs. And it's much more economical.

Many hospitals, schools and clinics are saving up to 50% on bandaging costs by using Tubegauz instead of ordinary techniques. Special easyto-use applicators simplify every type of bandaging, and give greater patient comfort, And Tubegauz can be autoclaved. It is made of double-bleached, highest quality cotton. Investigate for yourself. Send today for our free 32-page illustrated booklet.

Surgical Supply Division The Scholl Mfg. Co. Limited 174 Bartley Drive, Toronto 16, Ontario
Please send me "New Techniques of Bandaging with Tubegauz".
NAME
ADDRESS

THE SCHOLL MFG. CO. LIMITED



D

New! A COMMONSENSE APPROACH TO CORO-NARY CARE: A Program, by Marielle Ortiz Vinsant, R.N., B.S.; Martha I. Spence, R.N., B.S., M.N.; and Dianne E. Chapell, R.N., B.S. Focusing on major problems associated with myocardial infarction, this new program allows students to prepare realistically and systematically for their responsibilities in coronary care. Through an approach based on thorough knowledge of normal anatomy and physiology, it demonstrates how to deduce the clinical consequences of pathologic changes. Each carefully prepared unit depends on previous ones, resulting in a meaningful integration of information that enables students to assume coronary care with confidence. October, 1972. 222 pages plus FM I-XIV, 7" x 10", 243 illustrations. \$6.25.

New! DECISION MAKING IN THE CORONARY CARE UNIT - A Manual and Workbook for Nurses, by William P. Hamilton, M.D.; and Mary Ann Lavin, R.N., B.S.N., M.S.N. The simulated situations in this new text can provide students with the clinical experience they need - before a human life is at stake. Supplying much more than basic concepts of coronary conditions, its 123 realistic cases provide enough information to help the student determine what treatment goals, actions and methods of evaluation are most appropriate. A final chapter containing 60 miscellaneous cases aids in evaluation of progress. September, 1972. 150 pages plus FM I-X, 7" x 10", 124 illustrations. \$4.50.

INSTRUCTOR'S NOTE: To receive a complimentary copy for firsthand evaluation, write to the Textbook Department, mentioning your position, course and enrollment.

New! UNDERSTANDING ELECTROCARDIOG-RAPHY: Physiological and Interpretive Concepts, by Edwin G. Zalis, M.D., F.A.C.P., F.C.C.P.; and Mary H. Conover, R.N., B.S.N.Ed. The comprehensive explanation of basic heart anatomy and the detailed discussion of all aspects of electrocardiography mark the significance of this well-detailed new text. Physiological interrelationships of all major heart functions are delineated, then redefined in light of all the muscle action's electrical potential. Your students learn how and why muscle movement can be processed electronically into various types of visual graphs. Electrocardiography equipment is discussed in depth. August, 1972. 192 pages plus FM I-XII, 7" x 10", 341 illustrations. \$6.05.

New! COMPREHENSIVE REVIEW OF PHARMA-COLOGY IN NURSING, by Betty S. Bergersen, R.N., M.S., Ed.D. Using a concise question-and-answer format, this easy-to-use new text helps students review and reinforce their knowledge of all the major aspects of pharmacology related to nursing. Pharmacologic principles, administration of drugs, specific drugs which act on the various body systems and toxicology are discussed. A pertinent, up-to-the-minute chapter provides new insight into the recognition, control and treatment of drug abuse. December, 1973. Approx. 136 pages. About \$4.50.

New! INTRAVENOUS MEDICATIONS: A Handbook for Nurses and Other Allied Health Personnel, by Betty L. Gahart, R.N. Put complete, specific STAT information at your students' fingertips with this concise new handbook that provides one convenient source of information on intravenous medications. Clearly and simply presenting pertinent information on the intravenous use of drugs, it discusses dosage, therapeutic reactions, indications, precautions, contraindications and antidotes for each drug. Sensitivity reactions are fully examined. For ease of reference, all drugs are cross-indexed by both generic and trade names. June, 1973. Approx. 184 pages, 6" x 9". About \$4.75.

New! AGING AND MENTAL HEALTH: Positive Psychosocial Approaches, by Robert N. Butler, M.D.; and Myrna I. Lewis, ACSW. Help students gain a down-to-earth understanding of how they can help the elderly reach their full potential with this unique new book that gives the complete picture of the aged in America — including economic and everyday aspects. Old age is shown as a normal developmental stage of life, with emphasis on normal and abnormal health patterns and intervention, in both institutional and noninstitutional settings. The prevention of illness is dealt with extensively, as are organic and functional disorders of the aged. April, 1973. Approx. 320 pages, 7" x 10", 25 illustrations. About \$5.95.

New! BEHAVIOR MODIFICATION AND THE NURSING PROCESS, by Rosemarian Berni, R.N., B.S.; and Wilbert E. Fordyce, B.S., M.S., Ph.D. Let this informative new text provide students with a clear understanding of the rudiments of behavioral analysis. Succinctly outlining necessary procedures, it systematically applies learning theory and conditioning principles to the modification of deviant or disordered behavior in patients. Discussions range from analysis of behavior through reinforcement of behavior, and deal with the skills of systems management, ethical issues and future trends. June, 1973. Approx. 120 pages, 5½" x 8½", 9 illustrations. About \$3.95.

New! THE GROUP APPROACH IN NURSING PRACTICE, by Gwen D. Marram, R.N., B.S., M.S., Ph.D. Let this unique new book help students clearly understand the theories of group process, group leadership and group methods, as well as the therapeutic potential of groups. Describing the potential scope of group work in nursing, it illustrates the theoretical frameworks that guide study and practice in this area. Helpful group studies show how the nurse can intervene therapeutically. Group psychotherapy, therapeutic groups, growth and self-actualization groups, selfhelp groups and reference groups are all discussed. Other pertinent topics include typing behavior, basic group leadership functions and special techniques. June, 1973. Approx. 256 pages. About \$5.50.

New 3rd Edition! A TEXTBOOK FOR NURSING ASSISTANTS, by Gertrude D. Cherescavich, R.N., B.S., M.S. The carefully updated new edition of this widely adopted text focuses on the nursing assistant's role on the health care team. The student is given a clear understanding of the "why's" of the procedures she performs. In this revision, techniques have been simplified, disposable equipment emphasized and reusable equipment deleted. The section on isolation has been thoroughly updated. Study and discussion questions, glossaries of terms and sources of additional information are provided as learning aids. A helpful teaching quide is provided free of charge to instructors adopting this new edition. June, 1973. Approx. 468 pages, 7" x 10", 179 illustrations. About \$10.00.



# Here is a new, fast and sterile way to prepare Xylocaine infusions

for life threatening arrhythmias



# **Xylocaine**®

(Lidocaine Hydrochloride Injection, Astra Std.)

ne Gra

- The special 5 ml transfer syringe contains 200 mg/ml Xylocaine and can be added to infusion set-ups without removing solution from infusion flask or bag
- Cuts preparation time in half
- Easy and convenient to use
- · Adds another link to the sterility chain
- Disposable
- Clearly labeled for positive safeguard against error

ASTRA Pharmaceutical Division, Mississauga, Ontario



## news

# Canadian Nurse Awarded

# 3M Nursing Fellowship

Genera, Switzerland - Alice J. Baumgart, Vancouver, has been awarded the 3M nursing fellowship for 1973. The International Council of Nurses selected her from 33 candidates nominated by national nursing associations.

Ms. Baumgart plans to use the \$6,000 fellowship for doctoral studies of health service problems and planning of health services, at a Canadian university. She is acting director of the division of interprofessional education at the health sciences center, UBC.

Following completion of her doctoral studies, Ms. Baumgart plans to teach in university and do research on nursing and its place in Canadian health ser-

"Increasing attention is being given to planning for health services in Canada," Ms. Baumgart said, "but much improvement is needed in ways of approaching public decisions and means of analyzing and evaluating policies and programs relative to these

"Nursing, as the largest manpower group in health services, has a vital interest in such developments. There are few nurses with a broad background in health services who can build a bridge between needs and aspirations of the nursing profession and the results of public policy in health care."

An active member of the Canadian Nurses' Association, Alice Baumgart was chairman of the nursing education committee from 1970 to 1972, and has written several articles for The

Canadian Nurse.

She holds a B.S.N. degree from U. of British Columbia and a master's degree from McGill U.; she speaks both French and English.

Ms. Baumgart is the fourth 3M Fellow. Previous winners were Berenice King, New Zealand (1970), Junko Kondo, Japan (1971), and Margaret Dean, India (1972). The fellowship is sponsored by the Minnesota Mining and Manufacturing (3M) Company and administered by ICN

Each one of this year's 32 other national nominees will receive an award of \$200 from the 3M Company.



Alice J. Baumgurt

**CNA/CMA/CHA Committee Favors Control Of Drug Advertising** 

Ottawa — The joint committee of the Canadian Nurses' Association, Canadian Medical Association, and Canadian Hospital Association has supported the health protection branch of the department of national health and welfare in its action to control drug advertising.

In making this decision at a meeting at CMA House February 12, 1973, the joint committee voted that after each association receives the approval of its board for this stand, it will write a letter supporting the health protection branch campaign to reduce the advertising of drugs. CNA's board was to discuss this at its April meeting.

It was noted at the joint committee meeting that the Canadian Advertising Council was setting standards for television advertising of drugs; in Quebec, specific legislation in regard to advertising children's drugs had been developed; and at the federal level, the

legislation existed but the health protection branch needed support to

The committee agreed to try to educate its members about the overuse and misuse of prescription drugs. It also supported the resolution from the 1972 general meeting of the Canadian Nurses' Association "That the CNA convey the concern of nurses to CMA, CHA, and Canadian Pharmaceutical Association regarding the overuse of drugs and the misuse of prescription drugs both in and out of hospitals.

In addition to supporting the CNA resolution, the committee agreed to bring the suggestion to the joint meeting of the executives of the Cana-Pharmaceutical Association, Pharmaceutical Manufacturers' Association of Canada, and the CMA on

April 16.

**CNA Research Officer Heads** FP Research Advisory Group

Ottawa - Nancy Garrett, CNA research officer, was chosen chairman of the newly appointed national advisory committee on research in family planning, at the group's first meeting on March 14.

Appointed for a three-year term by the minister of national health and welfare, the five-member advisory committee makes the final review of grant proposals for family planning

research projects.

Other members of the committee are: W.A. Armitage, school of social work, U of Alberta, Calgary; Michel Bérard, chief of obstetrics and gynecology, Notre Dame Hospital, Montreal; Renée Cloutier-Cournoyer, department of sociology, Laval U, Quebec; and J.C. Nash, health studies program, department of kinesiology, University of Waterloo, Ontario.

#### International Nurses' Day **Focuses On The Environment**

Geneva, Switzerland - "The nurse's role in safeguarding the environment" is the 1973 theme for international nurses' day May 12—the date that commemorates the birth of Florence Nightingale. This year is the 153rd anniversary of her birth.

It was the International Council of

Nurses that agreed in 1965 to recognize May 12 as international nurses' day. A message from ICN gives some historical perspective to this year's theme. "When Florence Nightingale cleaned up the military hospitals in the Crimea, when she reorganized the drainage and water supply systems . . . and stood by . . . to see that waste tubs were emptied, she made a momentous contribution to safeguarding the human environment."

ICN points out that all nurses have responsibilities and opportunities to safeguard the environment. "The knowledge that nurses have built up in their profession, their long experience in matters of ventilation, temperature control, sterilization, contamination, diets, noise abatement, and the many other environmental factors which concern patient care and the maintenance of health can be extended. . . .

To help protect the environment, ICN suggests nurses influence those responsible in places of work and inform individuals of the steps they can tollow to protect their own health and that of their families, communities, and planet.

ICN says that such action requires nurses to be informed on matters, such as:

- Nonpolluting disposal of wastes. For example, are there filters in the incinerator chimneys?
- Nonpolluting materials, which should be purchased by individuals and by institutions.
- Irreplaceable or rare natural resources, which should not be wasted, such as paper and other wood products; electricity, power-, and heat-producing resources; aluminum; water; and food.
- Recycling of things such as paper, glass, and water.

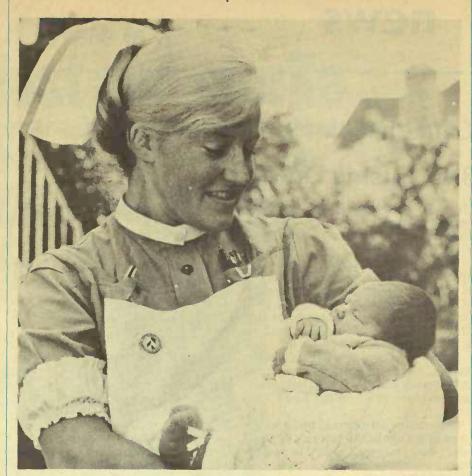
ICN is also appealing to nurses in member countries to send copies of policy statements, citations, articles, speeches, photographs, and any other information about the celebration of May 12 to the international nurses' headquarters in Geneva.

It would like to receive news of actions taken to protect the environment so that "ICN can spread the news of [these] accomplishments and help nurses make a planetary impact.'

At the United Nations Conference on the Human Environment in Stockholm, Sweden, in 1972, more than half a million nurses were represented by ICN's executive director, Adele

Herwitz.

#### Memorial Fund Set Up In Name Of Judith Hill



A memorial fund in England has been established in the name of Judith Hill, the nurse killed in the November 1972 crash in the Northwest Territories (Names, Feb. 1973, page 47). Dr. Andrew Watson, Mahone Bay, Nova Scotia, is helping to raise funds in Canada. This fund will enable two English and two Canadian nurses to exchange jobs and thus promote better understanding of nursing in the two countries. Dr. Watson, a native of Devou. England, and a close friend of Judith Hill's parents, was responsible for bringing the nurse to Canada. She worked at Fishermen's Memorial Hospital in Lunenburg, Nova Scotia, for nine months after she arrived, and always regarded Nova Scotia as her second home. She returned several times to spend holidays with the Watson family. After returning from a visit to the Hill family in England, Dr. Watson said: "Judy's family would like her to be remembered in a very practical and useful manner, so they and some friends decided to establish this fund, which will be used to assist nurses to exchange travel in both countries." Anyone who wishes to donate to the fund can send contributions to the Judith Hill Memorial Fund, Kingsbridge, Devon, U.K., or clo the Bank of Montreal, Mahone Bay, N.S. The bank will forward all money to England, and contributors will receive receipts from there.

#### New Entrance Procedure Adopted For N.B. Diploma Schools

Fredericton, N.B. — The New Brunswick Association of Registered Nurses, at the request of health minister Lawrence Garvie, has implemented a new central application procedure for students seeking entrance to the diploma schools of nursing in the province.

This procedure, recommended in the Report of the Study Committee on Nursing Education, was developed by directors of the diploma schools admitting students, the department of health, and NBARN

Mr. Garvie explained that the central application procedure will make the entire system more efficient and less costly because there will no longer be multiple processing of applications. "The system will provide accurate

(Continued on page 15)

## **Double-Tex Surgeons' Gloves**

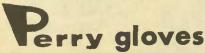


Need extra protection against slippage when you're handling slippery metal, glass and plastic surgical instruments? Try Perry's Double-Tex® sterile, surgical gloves with light, velvet-textured palms.

You'll also get another exclusive Double-Tex feature. A special textured interior surface. Designed to protect against "in-the-glove slippage" caused by perspiration build-up during long procedures.

Double-Tex's strong, but thin, palm prevents binding. In addition, specially designed, curved fingers make Double-Tex a comfortable glove that is not fatiguing during long procedures.

Available in white and brown latex. Sizes 51/2 through 9. Packaged in convenient peeldown, nonresealable outerwrap. Innerwrap provides a 276 square inch sterile field. Double-Tex. Just what you asked for and just from Perry.



AFFILIATED MEDICAL PRODUCTS LIMITED 90 Commercial Avenue, Ajax, Ontario



# UROGATE\* The total system to meet all your irrigating requirements

Solutions
Administration sets
Drainbox\*\*

Now with the Urogate System you can choose from four handy big-mouth bottles.

You'll like the new 500 ml. and 1,000 ml. sizes. They're just right when you need smaller volumes of pour solutions.

Or, where you need *larger* volumes, the familiar 1,500 ml. and 3,000 ml. Urogate containers are ideal.

Those generous 38-mm. openings are built for business! For example, you can empty the new 1,000 ml. bottle in 10 seconds. Or empty the 500 ml. bottle in just 7 seconds.

(Or, when you choose, pour a slow, carefully regulated stream.)

No mix-up with I.V. bottles on your shelf either: you can recognize the distinctive Urogate shape at a glance. What's more, these bottles accept only Urogate urologic sets. No chance of accidental intravenous infusion.

You'll find a choice of Urogate solutions and sets for all your surgical and urologic irrigating needs. It will be worth your while to learn the details. Why not talk to your Abbott Representative this week.

## **Urogate**



now available MRS. R. F. JOHNSON SUPERVISOR CHARLENE HAYNES MRS. HOLBROUN ANN COHN, L.P.N.



All White Plantic No. 510

CAR

# Name Pins 'n Things... from Reeves

#### IT'S EASY TO ORDER REEVES NAME PINS FOR YOURSELF OR FRIENDS!

Choose style you want, shown left. Print name (and 2nd line if desired) on dotted lines below. Check other into in boxes on chart, clip this section and attach to coupon

bottom left. Attach extra sheet for additional pins. NOTE SAVINGS ON 2 IDENTICAL PINS . . . more convenient, spare in case of loss.

LETTERING:\_ BACKGROUND COLOR (Plastic) LETTERING PRICES\* BESCRIPTION Engraved 1 Line | Engraved 2 Lines ☐ Black ☐ Dk. Blue ☐ White ALL METAL . . . rich, trim and tailored. Lightweight, smooth edges, rounded corners. Duoton Polishe Satin ☐ Gold Does ☐ 1 Pin 1.98 ☐ 1 Pin 2.58 169 2 Pins 3.25 2 Pins 3.85 Silve apply PLASTIC LAMINATE...slimmer, broader; engraved thru surface to contrasting core color. Beveled border matches lettering. White Does Does .95 Med. Green 559 2 Pins 1.65 2 Pins 2.30 (same name) apply apply METAL FRAMED 100 design; snow-white plastic with smooth, polished beveled frame only MOLDED PLASTIC ... Simple, si economical. Will never discolor 1 Pin .95 1 Pin 1.4 2 Pins 1.65 2 Pins 2.3 White 510 mooth rounded corners and edges

\*Please add 25¢ per order for 3 pins or less.

QUANTITY DISCOUNTS: 10-24 pins, deduct 10%; 25-99 pins, 15%; 100 or more pins, 20% 



SCOPE SACK neatly carries and protects Nursescope or any scope. Double-thick frosted flexible plastic, white vinyl binding,  $4\frac{1}{2}''$  x  $9\frac{1}{2}''$ . Your own initials help prevent loss. No. 223 Sack. 1.00 ee. Your initials gold-stamped, add 50¢ per

#### NURSES PERSONALIZED ANEROID SPHYG.

AREKUID SPHTU.

A superb instrument especially designed for ourses! Imported from precision craftsmen in W. Germany. Easy-to-attach Velore outh, lightweight, compact, fits into soft sim. leather zippered case 2½° x² 4° x 7°. Dia Caibrated to 320 mm., ID-year accuracy guaranteed to 23 mm. Serviced by Reeves if ever required. Your initials engraved on manometer and gold stamped on case FREE, for permanent identification and distinction. A wise investment for a lifetime of dependable service!

No. 106 Shave. 3.2.95 8a. No. 106 Sphyg. . . . 32.95 ea.



#### CAP ACCESSORIES (NAI)

CAP TOTE keeps your caps crisp and clean while stored or carried. Flexible clear plastic, white trim, zipper, carrying strap, hang loop. Stores flat. Also for wiglets, curiers, etc. 8½" dia., 6" high.

No. 333 Tote . . 2.65 ea., 6 or more . . 2.35 ea. Your initials gold-stamped, add 50s per Tote.



WHITE CAP CLIPS WHITE CAP CLIPS Rolds caps firmly in place! Hard-to-find white bobbie pins, enamel on fine spring steel. Eight 2" and eight 3" clips included in plastic snap box. No. 529 Clips . . 3 boxes for 1.95, 6 for 3.25, 12 for 49¢ ea.

MOLDED CAP TACS

Replace cap band instantly. Tiny plastic tac, dainty caduceus. Choose Black, Blue, White or Crystal with Gold Caduceus, or all Black (plain). The neater way to fasten bands. No. 200 Set of 6 Tacs... 1.25 per set. 12 or more sets 1.00 per set





METAL CAP TACS Pair of dainty ieweiry-quality Tacs with grippers, holds cap bands securely. Sculptured metal, gold finish, popors. 34" wide. Choose RN, LPN, LVN, Caduceus or Plain Caduceus. Gift boxed. No. CT-3 (Specify Initials), No. CT-2 (Plain Cad.) or No. CT-3 (RN Cad.) . . 2.95 pr.

SEL-FIX CAP BAND Black velvet SEL-FIX CAP BAND Black velvet band material. Self-adhesive, presses on, pulls off; no sewing or pinning. Reusable several times. Each band 20" long, pre-cut to popular widths: ¼" (12 per plastic bax) ½" (8 per box) ¾" (6 per box) 1" (6 per box) 5eeffy width under ITEM tolumn on coupon, No. 6343 Band. . . 1.75 per box



Zin

3 or more . . 1.50 es. TO REEVES COMPANY, Box C Attlebore Mass 02703

	The Real Property lies					CONTRACTOR OF THE PARTY OF THE	
ı	DROER NO.	ITEM	COLOR	SIZE	QUANT.	PRICE	Ī
	E. Control		1				P
							L
ľ					=94		Ī
ı							þ

Use extra sheet for additional items or orders.

INITIALS as desired: (Good idea . . . for distinctive identification)

TO ORDER NAME PINS, fill out all information in box top right, clip out and attach to this coupon.

i	I enclose \$(Mass, residents add 3% S. T.)
ı	Sorry, no COD's or billing terms available
	Send to
į	Street

No. 216 Nursescope . . . ings on quantity orders (left).

13.80 ea. ppd.
6-11...12.80 ea. 12 or more . . 11.80 ea.
Group Discounts include free Initials and Sack! \*IMPORTANT NEW FEATURE: New "Medallion" styling includes tubing in colors to match metal parts. If desired please add \$1. ea. to all prices above, and add "M" to Order No. (No. 216M) on coupon.

Duty free Duty free



KELLY FORCEPS So handy for every ourse! 5½" stainless steel, fully guaranteed. Ideal for clamping off tubing. Your own initials help prevent loss.

No. 25-72 Forceps . . . 2.75 ea. 6 or more 2.50 ea. Your initials engraved, add 50e per forceps.



### Free Initials and Scope Sack with your own Littmann Nursescope!



diaphragm stethoscope . . . a fine precision instrument, with high sensitivity for with high sensitivity for blood pressures, apical pulse rate. Only 2 ozs., fits in pocket, with gray vinyl anti-collapse tubing, non-chilling epoxy diaphragm. 28" overall. Non-rotating angled ear tubes and chest piece beautifully styled in choice of 5 jewel-like colors: Goldtone, Silvertone, Blue, Green, Pink."

FREE INITIALS AND SACK! Your initials engraved FREE on chest piece; lend individual distinction and help preual distinction and help pre-vent loss. Also FREE SCOPE SACK included, worth \$1, as described above right, (Free sacks not personalized, add 50¢ if initials desired.) Ideal for group gifts! Note big sav-ings on quantity orders (left).

SCISSORS Precision-made imported forged steel.
Professional quality, Guaranteed 2 years.



31/2" LISTER MINI-SCISSORS Tiny, handy, slip into uniform pocket or purse. Choose jewelers Gold or gleaming Chrome plate finish on coupon. No. 3500 Mini-Scissors . . 2.75 ea

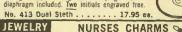
41/2" or 51/2" LISTER SCISSORS

above, but larger for bigger jobs. Chrome finish only No. 4500 (41/2") or No. 5500 (51/2") Scissors . . . 2.75

51/2" OPERATING SCISSORS Stainless steel, with sharp/blunt points. Beautifully polished finish No. 705 OR Scissors . . . 2.75 ea.

Your initials engraved, add 50c per scissors.

CLAYTON DUAL STETHOSCOPE Light weight imported dual scope; highest sensitivity: pulse rate. Chromed head tubes and chest piec 11/6" bell and 1/6" diaphragm, grey anti-collapse tubing. 4 oz., 29" long. Extra ear plugs and diaphragm included. Iwo initials engraved free. (CD) Duty free



Finest sculptured Fisher charms; Sterling or Gold Filled (specify under COLOR on coupon) For bracelet or pendent chain. Add to your collection! No. 263 Caduceus; No. 164 Cap; No. 68 Grad. Hat; No. B. Band. Scissors . . 3.49 ea.



(A)

14K PIERCED EARRINGS Dainty, detailed 14K Gold styles, for on or off duty wear. Shown actual size. Beautifully gift boxed.

Birthstone Colors (specify on coupon): JAN Garnet, FEB Amethyst, MAR Aqua, APR Crys-tal, MAY Emerald, JUNE Alexandrite, JULY Ruby, AUG Peridot, SEPT Sapphire, OCT Rose Zircon, NOV Topaz, DEC Blue Zircon.

No. 13/297 Caduceus; No. 13/276 Cross; No. 1/010 Gen. Cultured Pearl; No. 6/247 Birthstone \$ 5.95 per pair.

PIN GUARO Sculptured caduceus, with fine chain included. Attach your class or other valuable pin for extra safety. Pinback/safety catch, gold finished, indiv. boxed. A thoughtful gift idea, too.

No. 4240 Pin Guard . . . 2.50 ea.



ENAMELED PINS Beautifully sculptured status insignia, 2-color keyed, hard-fired enamel on gold plate. Oime-sized, pin-back Spacify RN, LPN, PN, LVN, NA, or RPh. on coupon. No. 205 Enam. Pin 1.95 ss., 12 or more 1.50 sa.





Ne. 791 (left) Deluxe Saver, 3 compt. change pocket & key chain . . . 6 for 2.98, 25 or more 35¢ ea. Nurses' POCKET PAL KIT

CDA

Handiest for busy nurses. Includes white Deluxe. Pocket Saver, with 5" Bandage Shear Iboth shown opposite page), Tri-Color ball-point pen, plus handsome little pen light 1. all silver finished. Change compartment, key chain.

No. 291 Pal Kit . . . . . . . 4.95 es 3 Initials engraved on shears, add 50¢ per kit.

BZZZ MEMO-TIMER Time hot packs, heat lamps, park meters. Remember to check vital signs, give medication, etc. Lightweight, compact (1½" dia.), sets to buzz 5 to 80 min. Key ring. Swiss made. No. M-22 Timer . . . . . 4.95 sa. 3 or more 3.95 sa.; 6 or more 3.50 sa.



#### CDM **EXAMINING PENLIGHT**

White barrel with caduceus imprint, aluminum band and clip. 5" long, U.S. made, batteries included (replacement batteries available any store). Your own light, gitt boxed. No. 007 Penlight . . . 3.88 ea. Your initials engraved, add 50g per light.

COMPLETE SATISFACTION GUARANTEED! All po





Endura NURSE'S WATCH Fine Swiss-made waterproof timepiece. Raised easy-to-read white numerals and hands on black dial, luminous markings. Red sweep-second hand. Chrome finish, stainless back. Includes black velved strap. Gift-boxed, with 1 year guarantee. Very dependable. Includes 3 initials engraved rREE!

19.95 ea. No. 1093 Nurses Watch . . . . . . . . 19.95 ea.



CAR NURSES BAG A lifetime of service NURSES BAG A lifetime of service for visiting nurses! Finest black ½6" thick genuine cowhide, beautifully crafted with rugged stitched and rivet construction. Water repellant. Roomy interior, with snap-in weshable liner and compartments to organize contents. Snap strap holds top open during use. Name card holder on end. Two rugged carrying straps. 6" x 8" x 12". Your initials gold embossed REE on top. An outstanding value of superb quality. No. 1544-1 Bag (with liner). 37.95 ea. Extra liner No. 4415. . . . 6.95 ea.

Fast-Action TOURNIQUET Strong, lightweight Velcro® strap applies, adjusts and releases instantly on any limb. Positive holding power, self-adjusting tension, eliminates "pinch". For blood samples, emergencies.

Duty free emergencies. Duty free
No. 2017-1 Tourniquet . . . . 2.69 ea.

O. 2017-1 Formand State of Sta ROSS PEN World-famous ballpoint, with sculptured caduceus emblem. Full name FREE engraved on barrel (include name with coupon). Refills avail, everywhere. Lifetime guarantee.

3502 Chrome 8.00 ea. No. 6602 12kt. G.F. 11.50 ea.

TRI-COLOR BALL PEN Write in black, red and blue with one ball point pen, p of the thumb changes point (and color). Steno fine point (excellent r charts), Polished chrome finish. A handy accessory for every nurse! 





#### news

(Continued from page 10)

information on all applicants to diploma schools, and allow assessment of the regional distribution of qualified students," he said.

Under the new system, the schools will send applications to a central location for sorting, although the schools will continue to make final decisions on successful applicants. According to Jean Anderson, NBARN executive secretary, students will apply as usual to the school they prefer, indicating any second choice. Diploma schools will submit their applications to the NBARN office, where a master list of information on each applicant will be compiled.

Each May, NBARN staff will meet with directors from the schools to assess the applications. After provincial examination results are released, there will be a second meeting to finalize the selections.

Diploma schools of nursing that will be admitting students in September 1973 include those in Saint John and Edmundston, both offering two-year programs, and the Dr. Georges L. Dumont Hospital School in Moncton, offering the three-year program. The university nursing schools in Moncton and Fredericton will continue to admit students as in the past,

#### **RNABC Statement Urges Halt To Unplanned Proliferation** Of Health Workers

Vancouver, B.C. — A statement issued by the Registered Nurses' Association of British Columbia in March calls for a halt to the proliferation of health workers involved in nursing care.

Margaret Neylan, RNABC president, noted that the unplanned emergence of new categories of health workers to meet increased demands for nursing services contributes to fragmentation of patient care.

She said: "Population growth, advances in knowledge and technology, and improved living standards have resulted in increased demands for available services and personnel to provide health services. The response to those demands in British Columbia has been an uncoordinated and shortsighted development of a multitude of facilities, educational programs, and categories of workers."

RNABC's statement recommends that the appropriate federal and provincial government departments, the B.C. Hospitals' Association, and the nurses' association discuss anticipated nursing care personnel needs. It also reiterates the association's stand that nursing services should be provided only by registered nurses and licensed practical

Copies of this statement were sent to health minister Dennis Cocke, education minister Eileen Dailly, and federal manpower and immigration minister Robert Andras.

#### **Dental Plan For Nurses Included** In Manitoba Hospital Agreement

Thompson, Man. — For the first time in Manitoba, nurses working in a hospital have signed a collective agreement that includes a paid dental plan. This three-year agreement, covering some 60 nurses, became effective March 1, 1973, at Thompson General Hospital in northern Manitoba.

The dental plan provides for routine dental work, such as fillings, extractions, oral surgery, and two checkups a year. Nurses' dependents are also included.

In addition to the dental plan, the nurses received improvements in sickness and accident insurance, more paid holidays, and a salary increase in the first year from \$585 to \$620 a month for beginning nurses. The 1973 rate will be increased to \$655 in March 1974 and to \$690 the following year.

This was the first agreement negotiated by the Thompson General Hospital registered nurses' association.

Representative Of Public Named To NBARN Governing Body

Fredericton, N.B. — For the first time, two nonnurses have been named to the council of the New Brunswick Association of Registered Nurses. Dr. Austin M. Clarke is the first representative of the public to be elected to the association's governing body. Albert Cowie, president of the Association of New Brunswick Registered Nursing Assistants, has been named to the council to represent the nursing assistant group.

In announcing these appointments, NBARN president Apolline Robichaud said NBARN is the first provincial nurses' association to approve lay representation on its board of directors. "To our knowledge, we are also the first professional association in New Brunswick to admit the public to our governing body," she added.

According to Ms. Robichaud, the association believes that public representation will help the consumer and

THE CANADIAN NURSE 15

the profession reach decisions affecting the quality of nursing care in the province. "Nurses in the province said 'yes' to the idea at our annual meeting last May and approved the necessary bylaw

changes," she explained.
Dr. Clarke, a graduate of McGill Medical School, has held various positions in public health in New Brunswick. In 1970, he retired as executive director of the Moncton Hospital after 15 years. He is past president of the New Brunswick Hospital Association, Maritime Hospital Association, N.B.-P.E.I. branch of the Canadian Public Health Association, a former director of the Canadian Council on Hospital Accreditation, and an honorary life member of NBARN.

Both Dr. Clarke and Mr. Cowie, who attended their first council meeting in February 1973, are the first men on the NBARN council. The council is composed of the elected officers, chairmen of standing committees, presidents of the association's 11 chapters, and the two new appointees. Additional members-at-large may be appointed to bring council membership to 25.

**B.C.** Hospitals Need More Nurses **To Avoid Summer Staffing Problems** 

Vancouver, B.C.—The Registered Nurses' Association of British Columbia is recruiting nurses from other provinces and is helping to sponsor refresher courses for nurses in an effort to ease anticipated summer staffing problems in the province's hospitals.

RNABC has placed advertisements that inform nurses in other provinces of the growing number of temporary and permanent general staff positions for registered nurses and graduates

in B.C. hospitals.

Frances McDonald, assistant director of personnel services in charge of the RNABC placement service, said hospitals reported 172 vacancies in general staff positions in January 1973; there were 114 vacancies in January 1972 and only 40 in January 1971.

According to RNABC, vacancies have become more difficult to fill because of expanded hospital facilities, especially in extended care. A total of 1,079 new beds in acute and extended care have been added in the province since 1971, Ms. McDonald said.

This spring, refresher courses have been scheduled to enable nurses who have been out of practice for some time to return. A 16-week course for

**Nurses Model Latest Fashion** 



Spring means a change of fashion for some 500 nurses employed by the department of national health and welfare, medical services, in the quarantine service and Indian and northern health services. Their new uniform includes a blazer, pleated skirt, A-line skirts in wool or cotton, winter and summer slacks, drip-dry blouses, trench coat, winter coat, handbag, and silk scarf. Red, white, and blue are the colors. The uniform for male nurses consists of a blazer, trousers, drip-dry shirts, tie, and trench coat. Montreal designer Michel Robichaud created the new fashions to be smart looking, warm, and durable for the nurses who travel and make house calls. Each region is setting up a program for introducing the uniforms and deciding which items are appropriate.

13 nurses, which began in Revelstoke in January, was initiated by the Revelstoke chapter of the RNABC. Queen Victoria Hospital in Revelstoke, the RNABC, and the University of British Columbia division of continuing nursing education are cosponsors of this course, which is being conducted as a pilot project. It may be held in other areas of the province at later dates.

On April 15, Vancouver General Hospital began a five-week refresher course, involving a work commitment. Both temporary and permanent positions will be available this summer at the hospital.

The B.C. Institute of Technology in Vancouver offered a refresher course for 15 nurses. It began April 24 and ends June 15. Although the Institute has conducted other refresher courses, this was the first one funded by Canada

Manpower.

**RCAMC Bursary Open To Nurses** 

Ottawa — The Royal Canadian Army Medical Corps Fund announces an annual bursary of \$300. Dependents of: noncommissioned members of the RCAMC, Canadian Forces, who have been accepted for career status; noncommissioned members or former members of the RCAMC, Canadian Forces, or Canadian Army (Regular), who have served a minimum of five years subsequent to 1950; and former RCAMC noncommissioned members of the CASF (Korea), are eligible.

The bursary will be awarded to a dependent who has achieved satisfactory scholastic standing in the entrance, first, second, or third year of a recognized Canadian university, teachers' college, school of nursing, or institute of technology course requiring a minimum of 2400 hours of instruction.

Further details may be obtained from the Secretary, RCAMC Bursary, Surgeon General Staff, National Defence Headquarters, Ottawa, Ontario, K1A 0K2.

**MARN Responds To Government** White Paper On Health Policy

Winnipeg, Man. - In its response to the Manitoba government's 1972 White Paper On Health Policy, the Manitoba Registered Nurses' Association points out that the paper focuses on medical care, does not differentiate between health care and medical care in discussing health policy, and makes only limited reference to nursing.

The association's reaction is given in a nine-page paper, released in February 1973. In it, MARN agrees with the government "that the distribution of health service could be improved in many areas of the province," but emphasizes that "health service cannot be

considered in isolation. . . . "

MARN also states: "We commend the gradual establishment of district boards for health care. We sincerely believe that with the inclusion of health personnel in partnership with citizen participation, the climate will be set

(Continued on page 18)



Why not have the "black and white cocktail" served in your hospital in the Patient Cup™? The wide-mouth opening of this liquid unit dose container makes it easy for the patient to drink ORGANON'S smooth suspension of Milk of Magnesia and Cascara. (It's pleasant tasting, too.)

Each Patient Cup delivers a stable, precise dose of Magnesium Hydroxide (8%) equivalent to 30 ml. Milk of Magnesia U.S.P., and Cascara Extract equivalent to 5 ml. Aromatic Cascara Fluid extract U.S.P. Alcohol 3.5%.

No mixing. No pouring. No waste. Here is another opportunity for your pharmacy to extend its control of medication right up to the administration of a single dose. And, you'll make some more friends in the nursing department as well.

Order several shippers of Milk of Magnesia-Cascara Suspension. There are 100 doses in each, packed 10 to the shelf tray.

Set 'em up!



The Patient Cup



ORGANON CANADA LTD/LTÉE

INTRA MEDICAL PRODUCTS DIVISION TORONTO, CANADA

#### news

(Continued from page 16)

for the development . . . of a realistic and workable health care plan."

Although MARN agrees with the concept of the community health center as one approach to providing health care, it does not see it "as a panacea, but as one means of providing a diversity of service and particularly as a primary care center." Because only 11 percent of nurses in Manitoba work in the community, MARN warns that "careful scrutiny must be given to a redistribution of nursing manpower in a reorganized health care system."

Included in MARN's paper are recommendations that:

- The nurses' association must be responsible for establishing and maintaining standards of nursing care.
- Nurses should be included at all levels of health planning.
- Nurses should speak for nursing at the district board level.

- Indices of health must be delineated.
- Alternate choices of health care are needed.
- The baccalaureate nurse should be employed as the primary health care worker and programs developed to enable the diploma nurse to function in this role.
- In Manitoba, nurses must be prepared without delay at the master's level. with funds available for this and for continuing educational programs for all nurses.

MARN concludes its paper by stating it is ready to plan an approach with the health team, which "focuses upon helping the individual take more responsibility for his own health and the community to take more responsibility for its members.'

# 



## make no mistake about it!

Another patient is rushed into the emergency room, but even before diagnosis and treatment he must be identified or assigned a number. The reason is obvious and compelling: the right treatment must be given to the right patient...even if he is unconscious, confused, or unable to speak.

Hospitals throughout the United States are solving this real problem with a proven method of identification: Emergency Room Ident-A-Band by Hollister. Takes only seconds to apply to the wrist of each emergency patient. Hospital number and name (if known) are hand lettered right on the band. No insert card is required. Its distinctive color singles out the emergency patient from all others.



#### Founding Meeting Of Canadian Council Of Cardiovascular Nurses

Montreal, Quebec - All provinces were represented among the more than 200 nurses who attended the founding meeting of the Canadian Council of Cardiovascular Nurses April 9.

The council will operate within the general objectives of the Canadian Heart Foundation and will concern itself with:

1. fostering continuing education in cardiovascular nursing

2. promoting communication among nurses and related groups of health workers in cardiovascular health care

3. stimulating research designed to increase the body of knowledge in cardiovascular nursing

4. identifying needs and trends related to cardiovascular nursing at a national level

5. providing advice and assistance to the Canadian Heart Foundation and the provincial foundations and divisions.

The executive committee members elected are: chairman, Valerie Shannon, Montreal; vice-chairman, Joan Breakey, Toronto; general secretary, Cecile Boisvert, Montreal; membership secretary, E. Noble, Edmonton; treasurer, Jane G. Wilson, Toronto.

Any registered professional nurse interested in cardiovascular nursing may become a member of the council and should address queries to the membership secretary, c/o Canadian Heart Foundation, 1 Nicholas Street, Ottawa, Ontario K1N 7B7.

#### Ont. Nursing Education, Service **Well Represented At Conferences**

Geneva Park, Ont. — Two conferences on "Collaboration for Change," held at Geneva Park conference center in January, brought together 142 nurses

(Continued on page 20)

## **NURSES HAVE A SPECIAL** JOB TO DO. TYCOS HAS A SPECIAL 'SCOPE TO DO IT.

Because your job is different, you need different equipment. That's why we've engineered our nurse's stethoscope for your needs. From binaural to diaphragm, length to looks, it's a better instrument. Check these special features, then check your Tycos medical dealer.



Taylor Instrument Companies of Canada Ltd., 75 Tycos Drive, Toronto, Ontario. M6B 1W4

Special mushroom-shaped, soft neoprene rotating eartips. Let the 'scope swing as your head moves, get rid of that binding feeling. And the sound-seal remains unbroken, too.

> Special lightweight binaural. As rugged as the regular one, but better to carry around.

When it comes to moving about, we've made the tube longer. A full 21-inches. (Scope length — 291/2") Yet, because of our tapered tube design, you don't lose sound.

To know your own 'scope (as well as for fashion on the floor) we make the tube in four attractive colors — Kumquat Gold, Ultramarine Blue, Moss Green and Ebony.

The low-profile chest piece as well as being lighter weight, can easily be removed from the tube for replacement. And, to improve your patient popularity, it has a non-chill, snap-on diaphram.

See and try out the new Tycos® Nurse Stethoscope at your dealer

#### news

(Continued from page 18)

from all parts of Ontario. Among the participants were educators from universities and diploma schools, and service personnel from hospitals and

public health agencies.

Discussions about the concerns of teachers and students from the schools of nursing and the difficulties agencies have accommodating them when they come for field experience were based on the study "Teaching Behaviour in the Nursing Laboratory in Selected Nursing Programs in Canada." Dr. Helen Glass, director of the school of nursing at the University of Manitoba carried out this study and acted as a resource person for the conferences.

The participants also explored other concepts, such as the rights and obligations of teachers and staff in relation to what services are used for teaching, and the territory that teachers and students have as "guests" in the agencies.

Gina Bohn, a faculty member from McMaster University school of nursing

hondbook for

### CAMP NURSES

and other

### Camp Health Workers

Mary Lou Hamessley, R.N.

If you will be working as a camp nurse this summer, take this new book along with you. Sensible and down-to-earth, it is full of information you will use all summer long. Includes:

- A valuable 57-page chapter on treating the illnesses and injuries campers are most prone to.
- Detailed information on how to set up a camp health program.
- A chapter on sanitation which includes a resume of the camp health codes of 44 states.
- A chapter on the camp health center (equipment, procedures, health forms, etc.)
- AND MUCH MORE!

1973. 159 pages. Illus. Index. \$3.95

#### TIRESIAS PRESS, INC.

116 Pinehurst Ave., New York City 10033 Please send me copy(ies) of Handbook for Camp Nurses \$ \$3.95 each plus .20c shpg & handling if order is for only one copy I enclose Name

City

in Hamilton, showed ways of reducing risk in teaching. Students from the second year of the McMaster nursing program demonstrated a teaching method, using "simulated patients" programmed to respond in specific ways to simulate patients with specific symptoms. The students used a problem-solving method of gathering data to determine the nursing care the patient required.

#### **Kidney Foundation Program** Offers Wallet-Size Donor Cards

Montreal, Quebec — In a country-wide program to provide organs for transplantation, the Kidney Foundation of Canada is offering individuals 18 years of age and older a wallet-size donor card, which is legal when signed. With this card, an individual can donate all

or part of his body for medical purposes after death, although if he changes his mind about making a gift, he just has to tear up the card.

The donor card was made possible by the Human Tissue Act adopted and recommended for enactment by the Conference of Commissioners Uniformity of Legislation in Canada. During the past few years, nine provinces have adopted legislation making it legal to donate transplantable tissue.

Donor cards and brochures about organ donation are available free of charge from the Kidney Foundation of Canada, Box 422, Montreal 379, and from foundation branches and chapters throughout the country. These cards and brochures can be obtained in quantity for distribution by hospitals, and business community groups, organizations.

#### Travels With A Nurse In Rural Nova Scotia



Whether she travels by foot, car, or ferry boat, Pauline McNeil, RN, faces hills, snow, and ice in her varied work as a community nurse serving Long and Brier Islands in Digby County, Nova Scotia. She is one of four RNs working in a pilot project in community health nursing, conducted by the Nova Scotia department of public health. Her home office, on the windswept shore of Freeport Harbor, Long Island, consists of a mobile, 60-foot trailer with an office-examination room and waiting room containing all the basic necessities — including a crank-type telephone. As well as holding clinics daily in her trailer, Ms. McNeil organizes and conducts child health conferences, prenatal classes, and mental health counseling. Although she works closely with the islands' only doctor, she must deliver babies at home when necessary. All four nurses in this project give home care that includes suture removal, dressings, injection therapy, urinalysis, blood sample collection, inhalation therapy, and ostomy care.

**URIN-TEK** makes handling 3,300 gallons of urine specimens a year less onerous, odourous, time-consuming, space-taking and costly.

## Give us just 12 minutes and we'll show you how!



You'll see why major Canadian hospitals have switched to the URIN-TEK System for specimen collection, transportation, testing and analysis.

Our 12-minute audio/visual presentation shows how the URIN-TEK System is actually used in a hospital and why it offers so many attractive advantages, including easy assimilation into your normal routine with a minimum of staff instruction.

If you have seen the URIN-TEK System before and are not presently using it, this presentation will bring you up-to-date on the improvements we've made to make it even more practical.

Once you've seen our presentation, you may like to evaluate the URIN-TEK system in your hospital. We make that easy by offering a oneward trial at no cost, no obligation.

To arrange a showing contact your AMES representative or write Grahame Richards at this address.

Ames Company

Division, Miles Laboratories, Ltd., 77 Belfield Road, REXDALE 603, Ontario





AND FOLDERS **UPON REQUEST** 

# The Expanded Role of the Nurse: A Joint Statement of CNA/CMA

In April 1972, a joint committee comprised of four nurses, appointed by the Canadian Nurses' Association, and three doctors, appointed by the Canadian Medical Association, began a series of meetings to develop a position paper on the expanded role of the nurse. The committee's statement, modified after discussion by the directors of each association, has been accepted by the two boards.

#### I. Priorities

The Committee believes that improvements in the accessibility and effectiveness of Canadian health services can more appropriately be achieved by expanding the roles of nurses rather than by creating new categories of workers.

It sees potential for expansion of roles in many areas: in specialty practice such as obstetrics or orthopedics, in hospitals, in public health agencies, and in under-serviced rural and northern outposts. However, in the view of the Committee, priority should be given to expanding the role of nurses who work in direct and close association with physicians in the field of primary health care.

The term primary health care as used here refers

ed for individuals mainly on an ambulatory basis in the community or in their homes and includes: preventive and health maintenance services in the community; diagnostic and therapeutic services offered in physicians' offices, in clinics or in health centres; home care services for those who are ill; and rehabilitative services for those who require them. It provides care which is convenient, coordinated, continuous and comprehensive."—Boudreau, T.J. Report of the Committee on Nurse Practitioners, April 1972, page 2.

The Committee sees an increasing need for forms of team practice in which nurses and physicians cooperate in the provision of comprehensive care.

#### II. Roles and Responsibilities

The roles of the nurse and of the physician are interdependent. An increasing role is envisaged for the nurse in health maintenance. Moreover, selected responsibilities now tending to be handled by physicians can reasonably be delegated to nurses. Ultimate responsibility for diagnosis and establishment of a medical therapeutic plan will remain with the physician.

As the associate role is an evolving one, the Committee believes that for the present it is important to maintain a flexible and experimental approach to the matter of deciding what responsibilities for patients a nurse should undertake. Differences in patient populations, in how they are served, and in the mix of professionals working in a setting, will influence what a nurse would regularly do. Existing modes of providing primary health care and the educational and

experience backgrounds of nurses immediately available to fulfill such roles must also be considered.

The following areas of responsibility should serve as guides for establishing the activities to be undertaken by nurses:

- 1. In association with the physician the nurse may act as a first contact person to help to define the nature of a patient's problem, decide on the urgency of the need for medical attention, and deal with emergencies in the absence of the physician.
- 2. A nurse associated with a physician may accept delegated responsibility for patient management by:
  - a) carrying out procedures such as dressings, injections, vision and hearing testing, etc.;
  - b) making referrals to community agencies;
  - c) providing psychological support and counselling;
  - d) interpreting the physician's therapeutic regimen (including activity, diet, and medication);
  - e) providing ongoing health supervision for patients with stabilized chronic illness;
  - f) acting as a coordinator of services for the patient and his family who need a variety of services such as home care, public health, or social work as part of the treatment program.
- 3. Assisting in the health supervision of well children.
- 4. Assisting in the provision of prenatal and postnatal care.

The Committee realizes that while many nurses already carry out these responsibilities, some now working in the primary care field are grossly underutilized. This anomaly is due to many factors, including the excessive involvement of nurses in office management activities and the lack of educational opportunities to specifically prepare nurses for working in complementary roles with physicians in primary care.

#### III. Education

The Committee believes that educational opportunities should be provided to:

- 1. help nurses augment their knowledge and skills in primary care;
- 2. orient nurses and physicians to ways of organizing nurse-physician teams in primary care such that nurses can take on greater responsibilities for patient care.

To prepare nurses for expanded roles in primary care over the next few years, a two-pronged approach is suggested.

1. Short-term programs to assist members of the existing pool of nurses to move into practice in primary care settings in the next few years.

2. Over the long-term, modification of basic nursing programs to encompass in their curricula the knowledge and skills basic to giving primary health care.

#### A. Short-Term Programs

#### 1. Candidates

The Committee believes that with minimal added training, nurses with master's or baccalaureate degrees or with preparation or broad experience in community nursing are ready to fill expanded roles in primary care.

For such persons, a variety of educational offerings can be made available to augment their knowledge and skills in areas such as history-taking, physical assessment, and medical therapeutics relative to control of chronic conditions: a) on-the-job training; b) short continuing education courses of 2-4 weeks;

c) night school programs.

The Committee believes that with longer training programs, nurses with either a 2-year or 3-year diploma background, and with at least one year's work experience could be prepared to undertake a number of the responsibilities outlined as appropriate for nurses in an expanded role. However, it is not anticipated that the knowledge base of nurses so prepared will reach the level attained by those with degrees or public health preparation and broad experience.

2. Auspices of Educational Programs

Administrative responsibility for educational programs shall rest with the university faculties of nursing; however such programs need not necessarily be conducted in university centers.

3. Development of Programs

The Committee believes that educational programs should be developed conjointly by university faculties of medicine and nursing.

The Committee believes that medical and nursing educators should work with practitioners in the field of primary health care to establish flexible and high quality programs.

The Committee underscores the importance of the clinical component in programs to prepare nurses for extended roles, and urges that supervised practice and a period of fieldwork in an actual work situation in primary care be included.

The Committee recommends that in the form of a certificate or diploma, official recognition be given to nurses who successfully complete such programs. In addition, credits toward an academic degree should be granted if a nurse wishes to undertake further studies.

**B. Long-Term Educational Goals** 

The Committee believes that preparation for primary care should be incorporated into basic nursing education. Further, electives in primary health care should be made available in baccalaureate programs.

Opportunities should also be provided for persons with a bachelor's degree in nursing to undertake avanced nursing studies to prepare themselves for specialist roles in primary health care.

#### IV. Work Situations

#### 1. Organizational Base

The Committee suggests it would be advantageous to consider having both the physician and his nurse associate each affiliate with appropriate professional agencies and associations in the community (e.g., College of Family Physicians, Department of Public Health, or Victorian Order of Nurses). This would give both an organizational base, a colleagual (peer) advisory group, and a channel of communication within their profession.

#### 2. Remuneration

The Committee believes remuneration for nurses in extended roles in primary health care must be such that consideration is given to their education or experience background and the responsibilities required of them.

3. Continuing Education

The Committee further believes it is vitally important that time and monies be provided to nurses working in extended roles in close association with physicians to permit them to engage in meaningful continuing education.

# Surgical separation of conjoined twins

The authors hope that nurses involved in the care of Siamese twins will benefit from this description of the team approach for nursing care and surgical separation, and that they will communicate their own improvements in care to other nurses so that all can build on the experience of others.

Wendy S. Dirksen and Dorothy T. Meilicke

The incidence of conjoined twins is 1.50,000 to 1.80,000 births, with female twins outnumbering male twins by two or three to one. A search of the literature indicates not only that medical references on Siamese twins are relatively rare, but also that there is virtually no source to which nurses can turn for the nursing care of such babies.

On October 28, 1971, conjoined (Siamese) female twins were born at the University of Alberta Hospital in Edmonton.

This article will attempt to create relevant literature for nurses by describing the special nursing care approaches that were developed by the nursing staff in the nursery and the operating room for the preoperative and postoperative care associated with the surgical separation of these exceptional patients.

#### PREOPERATIVE PHASE

The mother, Gravida I, Para 0, had been referred to our hospital because of a suspected breech delivery of twins, although the conjoined feature had not been suspected. Routine radiological examination resulted in a diagnosis of conjoined twins, and preparations were immediately made for a cesarean section, which was done the following day.

The combined birth weight of the

twins, Cynthia and Christine, was 4,700 grams (10 lbs. 6 ozs.), and the Apgar scores for each were 4 and 7. Their type of bodily juncture was thoraco-omphalopagus, as they were joined from the xiphisternum to the umbilicus by a three-inch band.<sup>2</sup>

Extensive tests and investigation to determine the nature of involvement included: chest x-ray, gastrointestinal series, barium enema, angiogram, electrocardiogram, intravenous pyelogram, and cholecystogram. These revealed separate gastrointestinal tracts and separate vital organs. The only significant dual organ involvement appeared to be the liver. It was decided that the children should not be separated immediately.<sup>3</sup> The attending pediatrician, Dr. R. Weinberg, clarified the reasons underlying this decision in a personal communication:

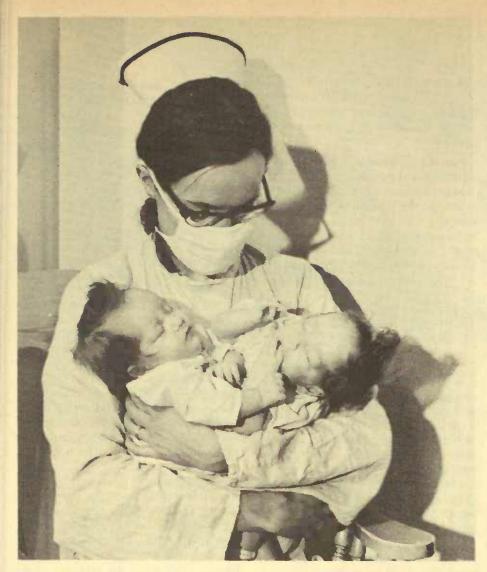
Wendy Dirksen is assistant director of special services, and Dorothy Meilicke is nursing supervisor, general and premature nurseries at the U. of Alberta Hospital, Edmonton, Alberta. They thank Dr. R. Weinberg, attending pediatrician; C. Egbert, charge nurse, premature nursery; C. Leask, OR supervisor; the nursing staff of the OR and premature nursery for their helpful suggestions; and Dr. S. Stinson, health services administration, U. of Alberta, for her assistance and encouragement in compiling this article.

"The initial period of investigation showed that the twins were separate apart from a band of tissue 7.5 cm., extending from the xiphisternum to the umbilicus and almost certainly containing a bridge of liver tissue.

"My decision to wait was based on the fact that the twins were healthy, and although I was concerned with the possibility of infection in one or both of the twins arising as a complication, I felt that waiting until after the neonatal period would allow the twins a smoother operative and postoperative period.

"Apart from those twins that share common vital organs, at which time surgery may become an emergency, authorities are divided as to early intervention or late intervention. Immunologically, the newborn is susceptible to gram-negative infections, and, because of hospital setting, staphylococcal infections, and I suspect that this is one of the major reasons suggested for early intervention. A further reason is infection in one of the twins producing an emergency situation, and this makes less than an ideal setting for major surgery."

One administrative policy immediately set was the strict control of information to protect the privacy and anonymity of the parents and children. One hospital spokesman was named in addition to the attending pediatrician



Babies following feeding. This photo was taken preoperatively.

to handle all publicity involving the twins; all public enquiries were directed to one or other of these individuals and only they were allowed to release information to the public or the media. We would encourage others to use such a policy in this type of exceptional situation, as it permitted the health team to focus entirely on the care of the infants.

The staffing pattern for the twins during their preoperative phase was one nurse to the two babies. The twins were considered to be routine care patients requiring a moderate amount of nursing care, that is, one to two hours of direct nursing care per shift per baby.<sup>4</sup>

#### **Nursing Objectives**

Senior nursing personnel immediately began to search the literature and to seek advice of physicians with regard to appropriate techniques and proce-

dures for care. A special film, Surgical Separation of Thoraco-Pagus Conjoined Twins, was obtained from The Hospital for Sick Children, Toronto, and was shown to the operating room and premature nursery staffs.

The nursing care plan for the twins' preoperative phase (six weeks), which was developed by the nursing staff, had as its seven main objectives to:

#### 1. Prevent infection

Actions: Protective gown and mask technique was required for all medical and nursing staff, parents, and grand-parents. This included careful handwashing with hexachlorophene soap.

Babies had pHisoHex baths every other day for five weeks, then daily until surgery.\* Tub baths were started at three weeks of age, the babies' own stainless steel tub being autoclaved before each use.

The twins were physically separated

from other nursery babies in an area of the nursery approximately 80 to 100 square feet.

Exposure to possible sources of infection was reduced by continuity of assigned staff, who were required to report off duty for sore throat, flu symptoms, rashes, and so on; restriction on viewing babies by non-essential hospital personnel; allowing no visitors, except parents and grandparents; autoclaving all toys before placing them in the crib; and scrupulous cleanliness of all equipment.

Good nutrition, with vitamins added at one week of age, helped increase resistance to infection.

#### 2. Promote weight gain

Actions: Babies were fed Similac formula three-quarter strength, days one to three; full strength, from day four.

Solids were introduced at three weeks, I tsp. rice pablum b.i.d.; at four weeks, infant-type fruit plus I tsp. pablum b.i.d.; and at six weeks, infant-type vegetables.

Sterile water or glucose water was given p.r.n. between scheduled feedings.

Babies were weighed daily, the goal for surgery being a total of 19-20 pounds.

Twins were always held during feedings. Methods of feeding included: two nurses simultaneously feeding a baby each; one nurse feeding first one baby, then the other; or feeding babies alternately during a feeding period to keep them contented.

## 3. Promote normal social and sensory development

Actions: Parents were given unrestricted opportunity to cuddle and stimulate their babies. The mother was encouraged to feed them when she found this possible.

\* Our pHisoHex routine was in existence prior to the recommendation by the American Academy of Pediatrics. See American Academy of Pediatrics, Committee on Fetus and Newborn. Hexachlorophene and skin care of newborn infants: Committee Statement. American Academy of Pediatrics Newsletter Supplement, Jan. 1, 1972.

Visual stimulation was fostered by bright, washable, plush toys placed in the crib within view of the infants; by a musical plastic, washable mobile positioned above the crib; and by having the twins wear red mittens for short periods to flash at each other.

Tactile senses were developed by leaving the babies' hands uncovered as much as possible. Auditory stimulation was provided by the musical mobile and by the voices of staff nurses during feeding and cuddling periods. Emotional security was promoted by encouraging the warm, close physical contact of parents and staff.

The babies were moved into a standard preschool crib when their combined weight reached 15 pounds.

#### 4. Provide good physical care

Actions: Babies were turned to alternate sides at least hourly. When handled, their bodies were snuggly wrapped to prevent undue strain on the joined area.

Skin around joined area was massaged and kept clean and dry to prevent breakdown. The cord was swabbed with alcohol q.i.d.\*\*

Passive exercises were given to limbs, especially legs, because of restricted range of motion.

Fingernails were kept short to prevent babies from scratching each other's faces.

## 5. Respect and maintain parents' request for anonymity

Actions: All queries were channeled through the two hospital spokesmen mentioned earlier.

No outside personnel or visitors were allowed to see the babies, and their surname was never mentioned outside the nursery.

## 6. Identify parents' anxieties and promote their understanding of and preparedness for surgery

Actions: Parents were granted unlimited visiting privileges, and were provid-

\*\* The babies had one common cord, directly below the join area (xiphisternum to the umbilicus). This cord contained four arteries and one vein. Due to the close physical proximity of the babies, cord care was particularly important, In addition, it is interesting to note that during surgery, each twin was given part of a "tummy button."

ed with coffee in the visitors' room.

Open communication regarding the babies' progress and condition was maintained among staff, physicians, and parents.

## 7. Provide as normal a parent-sibling relationship as possible.

Actions: Deliberate efforts were made to involve the parents in as many daily activities with their babies as possible. The parents were encouraged and taught to hold, feed, and diaper their children, and were given the opportunity to buy such things as toys and soothers for them.

A photograph album was started immediately to capture the growth and development of the twins.

#### **Concomitant Activities**

- The attending physician ordered routine laboratory work and tests to determine the extent of the conjoint involvement. The nursing treatments included recording the apical beats and observing circulation in the arms each time the babies were turned every half hour for one week. Gamma globulin (5 ml.) was given to each baby two days before surgery to increase passive immunity.
- A film about the twins, for later use as a teaching tool, was being made throughout their hospital stay.
- A multidepartmental meeting was held three weeks prior to the anticipated surgery to plan a trial surgical run and the surgery itself. The departments represented were: nursing (operating room and premature nursery), medical (surgeons and pediatricians), x-ray, labs, blood bank, pharmacy, medical administration, anesthesia, and hospital administration.

At this meeting, the importance of confidentiality was again stressed. The channels for publicity releases were restated, and the security personnel were requested to provide additional coverage the day of the actual surgery.†

The lines of communication regarding doctors' postoperative orders were also clarified at this meeting. It was agreed that the premature nursery staff would continue to be responsible for planning the space, equipment, staffing, and parental care in the premature area.

• Equipment and staffing were planned to meet those postoperative crises or complications most likely to develop, such as postoperative respiratory distress, hemorrhage, and/or infection.

The equipment on standby included: four isolettes (previously maintenance checked and cultured), two oxygen analyzers, two infant warmers, two infusion pumps, two respirators, two chest tube trays and thoracic pumps, and two tracheostomy sets.

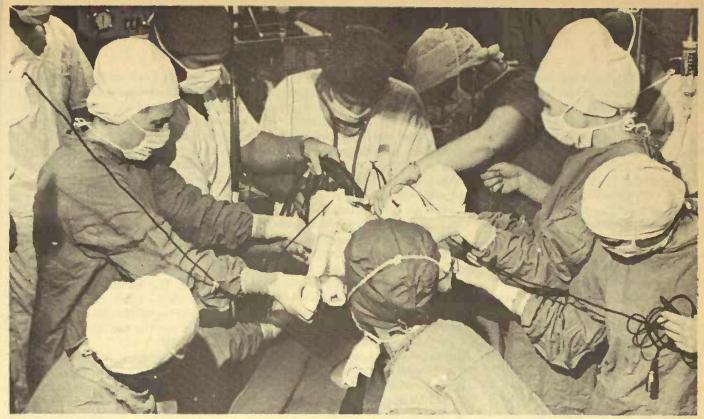
Staffing was planned on a one-toone basis for one week postoperatively, with emphasis on continuity of staff per shift. Relief staff were called in to free the permanent, experienced personnel to care for the twins,

- It was arranged that the babies would return to a separate nursery; its walls were to be washed immediately before surgery. A separate room near the nursery was reserved for the parents. Here, provision was made for a television set and for all meals to be brought to them for two days postsurgery. A specified staff member on each shift was assigned to help meet the parents' needs.
- The operating room nursing staff's primary objective was to provide an aseptic and minimally traumatic environment for surgical separation of the conjoined twins. To gain knowledge relevant to achieving this objective, the nursing staff asked the surgeons to explain their anticipated surgical approach. Together with the anesthetists, they all discussed problems that could occur during the procedure and determined the material and equipment required. After these frank and intense discussions, the nursing staff planned their part in the successful separation.

#### **Preparation for Surgery**

The operating room supervisor selected a team of seven experienced charge nurses who, in turn, chose a team leader, and decided scrub, circulating, and prep positions. The team

†Public interest demonstrated itself in the form of telephone calls to the unit, requesting information about the twins as well as conveying spiritual support. Letters were received from as far away as Australia. Curiosity seekers, arriving on the unit to see the twins, were a concern. A beautiful expression of genuine concern came from a Grade 11 class in the city, which sent many letters addressed to the babies.



Surgical draping of twins following application of "R" frames. Note specially made drapes with Velcro strip.

leader coordinated the team's activity and was to be in charge during the surgical procedure.

There were two scrub nurses, one to assist each of the two teams of surgeons. The two circulating nurses assured the availability of all supplies, and were to assist the anesthetists. The two prep nurses were to hold the babies during the surgical skin preparation, and later relieve the circulating nurses. This double staffing approach provided an adequately trained and prepared staff should another theater be required for skin closure. With tasks allocated in advance, minimal confusion and movement would occur in the theater and staff members would feel that all jobs were being well done.

The OR nurses and inservice instructor reviewed the literature and the before-mentioned film on the separation of conjoined twins. On the basis of this review, it was decided to have the surgical draping consist of four separate sheets specially made by the laundry. These were 21½ x 56 inches, had a semicircle cut out to accommodate the babies' joined skin, and a one-inch Velcro stripping along the rest of that edge. This draping was to maintain asepsis, regardless of the twins' position on the table, and make redraping unnecessary.

The nurses wrote surgeons' preference cards, using information gathered from the surgeons, readings, and team discussions. The cards prepared scrub and circulating nurses for the anticipated order of surgery. Instruments, sutures, and supplies were organized for the following basic surgical approach: peritoneal cavity, liver, bony structures, diaphragm, pericardial sac, and skin closure.

Plans were made to deal effectively with various anticipated emergency situations. Although fresh blood had been crossmatched, the nurses also had available: hemostatic material (Surgicel, bone wax, umbilical tape); a variety of liver sutures; hot normal saline; and extra instruments, such as Halsteds, Laheys, Debakeys, and ligature carriers.

The cardiac crash wagon and defibbrillator, two tracheostomy insertion trays, two #33 Hollinger tracheostomy tubes, and two respirators were outside the theater. The tracheostomy set was to go to the nursery if not used in the operating room. Four chest drains and two chest tube insertion trays were in the theater should a pneumothorax occur. The recovery room also prepared two mini-flask (100 cc.) pediatric underwater seal drainage units. If primary skin closure became impossible, Silastic sheeting, Marlex Mesh, Mersilene Mesh, and a variety of suture material were at hand.

A standby nurse was briefed on the entire surgical procedure, including each team member's function, and she was to watch the surgical procedure from the dome.

#### **Operating Room Equipment**

Two "R" frames, one secured to the back of each twin, were used to stabilize the patients for anesthesia and surgery.<sup>5</sup> Each frame consisted of an R-shaped wooden base, padded with half-inch foam rubber pads. Four Vclcro straps were attached to the base to help secure the baby to the frame. A hinged, five-inch extension supported the head but allowed for flexibility of the neck. The frame was 23" long and 6" wide.

The anesthetists needed two anesthetic machines, two physiological monitors, two thermal probes, one drug wagon, and one warming blanket for the OR table. To ensure accurate measurement of blood loss, tonsil traps were antifoamed prior to surgery, and dry sponges were to be used during surgery and weighed after use.

The surgeons required two cautery machines to ground each twin separately, and a cholangiogram frame on the OR table for operative and postopera-

tive x-rays. The photography stand, filming platform, and video machine were to be in the theater.

The operating room theaters, substerile room and air vents, and all equipment were to be cleaned the night

prior to surgery.

Personnel flow in the theater was to be limited on the day of surgery. "No Admittance" signs were to be placed on operating room doors. The medical director was to limit spectators, who were to view from the observation dome, and security guards were to patrol the dome entrance.

#### Trial Run

A trial run, with the babies present, was made the day before the actual surgery to determine if equipment were adequate, if placement of equipment and staff were correct, and to allow the nurses to practice draping the twins.

Nasogastric tubes, central venous pressure catheters, and cutdowns were inserted while the babies were in the theater. The twins were identified by "A" and "B" on their foreheads.

#### Day of Surgery

The operating room nursing staff arrived at 0700 hours to prepare the operating theater and set up instruments. They set the room temperature at 76°F and turned on the warming blanket.

At 0830 hours, the twins were delivered to the operating room.

Cautery pads, ECG leads, and thermal probes were placed and secured. The babies were turned on their faces and fastened to their R frames with the Velcro straps and 3" flannel bandage. The cautery cord, ECG leads, thermal probes, and IV tubing were tied together to form a single bundle.

Once secure on their R frames, the babies were anesthetized and raised above the OR table by two sterilegowned nurses.

A sterile pliofilm sheet †† was then tincture of Zephiran was used for a

placed on the OR table, and warmed

††Pliofilm is a waterproof sterile drape made by the University of Alberta laundry department. It consists of 36" x 36" heavy duty clear plastic, taped inside a folded small sheet, which is then placed in a wrapper and sterilized.

circular abdominal prep. Following this, the wet pliofilm was removed. The draping proceeded with the twins still held above the OR table, and a double sheet and fresh pliofilm were put on it. On top of these drapes, approximately 18" from the head of the OR table, a rolled towel was placed in position to support the skin join of the twins. Two of the specially made drapes were placed so the indentation surrounded the towel. The surgeons applied a small Steridrape to the lower surface of the twins.

The babies were then lowered to the OR table, and the bundle of tubing was secured to the mattress. A large Steridrape was applied to the upper surface of the twins, and joined to the Steridrape under them. Two more of the specially designed drapes were applied and the Velcro surfaces of the lower and upper drapes approximated. A double sheet downward from the twins' hips covered the end of the OR table and cautery machines. A small sheet covered the anesthetic screen, and two double sheets served as screening drapes from the anesthetic area.

The surgeons and nurses then regowned and regloved.

During the procedure, the surgical count for the case was a combined one for the two babies; however, each scrub nurse was responsible for the instruments, sutures, and sponges given to her team of surgeons.

Both twins had their incisions closed on the original OR table. This was more convenient for the surgical team and also lessened the chance of infection. Fortunately, none of the anticipated problems occurred, and the operation was completed at 1130 hours. Telfa and Aeroplast dressings were applied.

Cynthia and Christine, awake and crying, were returned to the premature nursery in sterile isolettes, accompanied by an OR nurse and an anesthetist.

#### **POSTOPERATIVE PHASE**

Using the preoperative nursing care plan as a basis, the following nursing objectives were developed to:

#### 1. Prevent infection

Actions: Protective technique was followed within the isolettes, but no gowns or masks were required for attending nursing personnel. Careful handwashing was continued.

Continuity of staff attending each baby on a one-to-one ratio was assured.

Skin care of the incision site was routine: the dressing was changed on postoperative day five, and covered with a light Telfa dressing until postoperative day 11, after which the incision was exposed.

No sterile linen was required, as the previously joined area was completely closed.

Routine skin care (daily sponge baths) was given to the rest of the body.

#### 2. Ensure proper nutrition

Actions: The babies had nothing by mouth for 24 hours due to their postoperative condition, and IV therapy per cutdown site was continued for four

Oral feedings were started on postoperative day 2, with glucose feeding. On day 3, half-strength Similac formula was given; day 4, three-quarter-strength Similac; day 5, full-strength Similac. Solids were reintroduced, beginning with Pablum on day 7, fruit on day 10, and vegetables on day 12.

#### 3. Stimulate twins' emotional, visual, and aural senses

Actions: Bright toys were placed in the cribs, and a musical mobile was suspended above them.

Tender loving care was encouraged

during and after feedings.

4. Provide emotional support to parents Actions: Parents had unrestricted visiting privileges, and a nearby room was made available for them. They could participate whenever possible in care of babies (feeding, diapering, TLC).

Communication between staff and parents was open and honest.

#### 5. Respect and maintain parents' request for anonymity

Actions: All public enquiries were channeled through the two hospital spokesmen.

The only visitors were the parents, grandparents, and operating room staff involved with the surgery.

#### 6. Prepare parents for care of babies at home

Actions: Every opportunity to teach was used when assisting parents in caring for their babies (feeding, diapering, bathing). Discharge instructions were explained.

**MAY 1973** 

#### 7. Prepare babies for their home

Actions: To promote normal sleep habits, the babies were placed in a darkened, quiet room at night, approximately one week before discharge.

A referral was sent to the public health nurse in the twins' home area.

#### **Concomitant Activities**

The attending physicians' orders for the postoperative period were routine vital signs, IV therapy for four days, nasogastric tube aspiration for three days, Hemovac drainage for three days, lab tests, daily weights, and gradual progression to a full-strength formula. No antibiotics were used before or after surgery.

The babies' postoperative period was, fortunately, uncomplicated.

Cynthia and Christine, smiling and healthy, were discharged 12 days postsurgery. Almost a year later, in December 1972, Dr. Weinberg wrote: "... I recently saw the Edmonton twins a few days after their first birthday and they were both developing quite normally. The parents informed me that the babies did not have any appar-

ent psychological trauma after they were brought home."

#### **HINDSIGHTS**

In retrospect, here are some changes we should have made, and now recommend.

- Because of the limited surgical success rate, nursing staff meetings should have been planned on at least a weekly basis to review the available literature and discuss staff's concern regarding the management of the twins and their parents.
- The film, Surgical Separation of Thoraco-Pagus Conjoined Twins, should have been shown sooner to provide the staff of premature nursery and OR with a greater understanding of the phenomenon. In our case, had the film been shown sooner to the other hospital personnel, curiosity would possibly have been reduced.
- A memo sent to each hospital area explaining the confidentiality and visiting restrictions regarding the twins might have saved the nursing staff considerable time and unpleasantness in enforcing these restrictions.
- In the OR, the total instrument, sponge, and suture setup for the case should have been done in the adjacent theater, and covered until the babies were anesthetized and draped. The surgical gowns, gloves, and surgical drapes for the case should have been on a separate table from the instruments to allow gowning and draping while the instruments were still covered. This would have safeguarded asepsis of the instrument sets, as the movement of personnel created many air currents. Then, with personnel gowned and the draping complete, the sets should have been moved into the theater and uncovered.
- A lock on the hinged head support of the R frame would have ensured stabilization of the head support.

#### REFERENCES

- 1. Bland, K.G. Xyphopagus twins. Report of obstetric and surgical management of a case. Cent. Afr. J. Med. 8:371-5. Oct. 8, 1962.
- 2. Kiesewetter, William B. Surgery on conjoined (Siamese) twins. *Surg.* 59: 5:860, May 1966.

Babies at completion of surgery. They stayed on same table during the surgery.



- 3. Simpson, J.S. Separation of conjoined thoracopagus twins, with the report of an additional case. Canad. J. Surg. 12:90, Jan. 1969.
- 4. Mucha, F. Nursing activity and patient categorization study - premature intensive care unit. Unpublished paper. Edmonton, University of Alberta Hos-
- pital, Methods study department, May 1971, p. 4, 17.
- 5. Kiesewetter, W. B. op. cit., p. 864-5.

#### BIBLIOGRAPHY

Metzger, Ruth S. On separating conjoined twins. AORN J. 3:3:71-81, May 1965. Simpson, J.S. Emergency separation of thoracopagus (twins conjoined at thorax) in the newborn period: importance of careful preoperative cardiac evaluation. Surg. 67:697-702, Apr. 1970.

Surgical Separation: 1. Tofield twins. 2. Bay City twins. 3. San Francisco. Birth Defects. Original article series. 3:1:66-142, Apr. 1967.



# How CNF scholars are selected

Since its incorporation in 1962, the Canadian Nurses' Foundation has financially helped 117 RNs to obtain a higher degree in nursing. The authors explain the criteria used to choose the recipients of the funds administered by the CNF.

Jane Henderson, B.N., M.Sc., and Barbara Archibald, B.Sc.N

Last June, fourteen Canadian nurses received a letter notifying them that they had been awarded a sizable sum of money from the Canadian Nurses' Foundation (CNF). Why were these nurses awarded this money? Who selected them and by what criteria?

To answer these and other questions, let's examine the entire process of application and selection by following the activities of one fictitious applicant, whom we'll call Paula Johnson.

#### Facts about Paula

Paula Johnson first wrote to the CNF in April, 1972.\* She was seriously considering entering a master's program in the fall of 1973, and decided early to find out about financial assistance. A letter of reply, accompanied by information on CNF, was sent to Paula, asking her to write for the necessary application forms in November.

On the first of November 1972, her request for forms arrived at CNA House, along with the information that she had obtained a baccalaureate degree in nursing in 1966 and had gained acceptance to a master's of nursing program in the autumn of 1973.

Any nurse applying for a CNF scholarship must submit baccalaureate transcripts, master's acceptance, and names of four references in addition to a completed application form. Paula escaped the problem many applicants face: as a graduate of 1966 she already had baccalaureate transcripts. If she had been currently completing a degree program, she might not have been able to submit the required transcripts or certification of acceptance to a master's program prior to the deadline of May first. This date, although inconvenient to some, is set so applicants can be notified of their success in time to plan autumn activi-

#### References

Applicants should consider carefully

Jane Henderson, a graduate of The Montreal General Hospital and McGill University, is Associate Executive Director of the Canadian Nurses' Association. Barbara Archibald, a graduate of Toronto General Hospital and the University of Western Ontario, is Assistant to the Secretary-Treasurer, Canadian Nurses' Foundation, Ottawa.

the question of the four references. The sources for these references are not stipulated on the application form. Only persons who have had recent contact with the applicant are really useful. For example, a suitable reference for a nurse who has just graduated from a diploma program may be the director of nursing of the school. As Paula graduated in 1957 and had not had continuing contact with her school, the director of nursing would probably be unable to provide a pertinent reference.

Realizing her application would be judged by a committee of academically and clinically successful nurses, Paula asked CNF to send reference forms to nurse educators and clinicians who could fairly assess her competence and ability to pursue a master's degree.

Friends of the applicant may or may not be appropriate sources for references. The applicant must decide whether or not her friends are able to judge her clinical and/or academic abilities.

#### Paula becomes No. 14

As soon as Paula's application has been completed, "profile sheets" are drawn up for later submission to the selection committee. Her name is removed from this sheet. As Paula's profile is the 14th to be prepared,

THE CANADIAN NURSE 33

<sup>\*</sup> All correspondence to CNF should be sent to the Canadian Nurses' Association headquarters (CNA House), where CNF business is conducted by CNA staff.

she becomes "No. 14." Information that Paula has provided, reference scores, and comments are transcribed verbatim. Now No. 14 is in the hands of the committee.

#### **Selection Committee**

Paula is curious to know who the selection committee members are. Their specific identity, however, is not made known for rather sound reasons.

The composition of the sevenmember selection committee changes yearly. Members are appointed by the CNF board of directors according to region, area of interest in nursing, and academic or clinical expertise. Since 1962, 56 different nurses have been involved in the selection process.

#### Selection process

At the outset of each yearly meeting, the committee establishes a passing score. The score decided on reflects the committee's definition of minimum requirements for funding. Each profile, taken in numerical order, is reviewed by all committee members simultaneously.

Number 14 takes its place. Each committee member assigns it a numerical score.

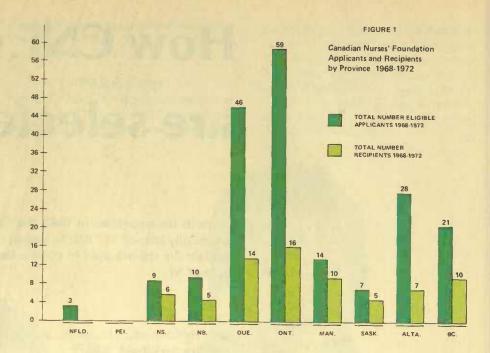
Through the application and selection process, Paula's abilities and potential to contribute to nursing in Canada are assessed twice. She is evaluated first by four persons whom she knows and considers appropriate to judge her ability, and then, as No. 14, her "profile" is judged by seven persons whom she does not know but whom the directors consider competent.

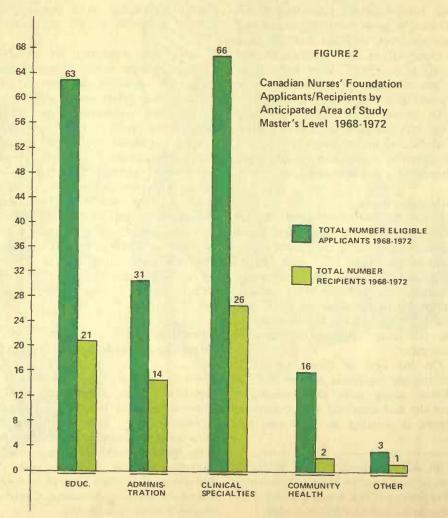
Two members of the CNF staff are present during the committee deliberations to answer questions on procedure, to fill in background information about university programs, and to record ratings.

When each committee member is satisfied that she has the necessary information on which to make a decision, she assigns a score to the profile's number. Each applicant thereby receives a score that is a composite of the ratings of the seven selection committee members.

All applicants are reviewed the same way. It has been common practice by past committees to review some of the carly profiles at the end of the meeting to insure that judgment has been consistent throughout.

Although reference is made to "a





meeting," the time involved may be less than a day or extended over a two-day period. The determining factor is the number of applicants.

After the meeting, the selection committee chairman submits a list of recommended applicants (by number) to the CNF board of directors. The directors then review recommendations in the light of available scholarship funds, and award grants accordingly.

Paula will be informed of the success or failure of her application by June or July. When each successful applicant has replied that she or he can accept an award in the context of CNF policy, the award recipients' names are made public. Only then will members of the selection committee find out who the award winners are.

#### What are Paula's chances?

Quite simply, Paula's chances of being awarded a fellowship are based on the degree to which her application meets CNF criteria for intellectual, clinical, and leadership ability. Because selection is based on the individual, rather than on an area of study or place of origin, geographical and clinical distribution of funds varies from year to year.

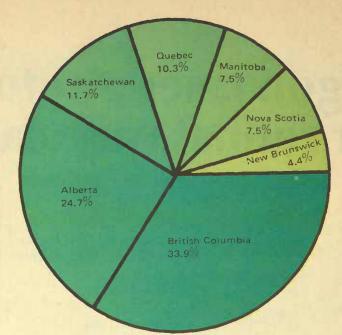
Figure 1 shows the number of applicants and recipients by province over a five-year period. Figure 11 shows the number of applicants and recipients, according to area of interest, over a five-year period.

#### What is the source of funds?

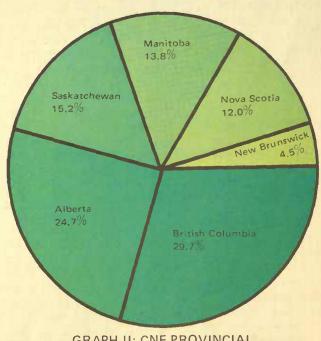
As a nonprofit corporation, CNF may receive donations from individuals or from groups. The most significant contributions toward maintaining the Foundation and furthering its objectives come from provincial associations. Sums of money are submitted and earmarked by the donor for one of four funds: administrative, scholarship, research, and capital trust. Some associations divide their yearly contribution by indicating that a certain percentage is to be allocated to each fund; on the other hand, some associations wish to support one fund more than others.

Donations made by a provincial association do not provide CNF membership to association members. Such donations provide membership to the associations as entities.

The two pie graphs show provincial association donations. The first graph



GRAPH I: CNF CUMULATIVE PROVINCIAL DONATIONS 1968-1972



GRAPH II: CNF PROVINCIAL **DONATIONS 1972** 

reflects five-year cumulative donations, and the second shows donations received in 1972.

#### Summary

CNF applications are received at CNA House between November 1 and March I each year. Information is transferred from application forms to

numerically identified "profile" records. These records are individually reviewed and assessed by a sevenmember selection committee. Recommendations are subsequently given to the CNF board of directors, which makes the final decisions. Anonymity is maintained until the names of award recipients are made public.

THE CANADIAN NURSE 35

# Argon laser photocoagulation for retinal vascular disease

This new mode of therapy has given hope of improved vision to patients who have visually-disabling vascular diseases.

David A. Rosen, M.D.

A wide range of diseases of small blood vessels (arterioles, capillaries, and venules) can interfere with vision. The damaging influences in these diseases occur either through frank leakage from the walls of the diseased blood vessels of serum or whole blood, through occlusion with subsequent infarction, or through the proliferation of abnormal blood vessels that are excessively "leaky" or that, because of their location in abnormal sites, may lead to massive and disastrous intraocular hemorrhage.

In general, the patients most vulnerable to the damaging effects of small blood vessel disease are diabetics and elderly people with degenerative vascular disorders. The injurious effects in either instance are especially grave when the abnormality affects the macular portion of the retina where the highest visual acuity and the most accurate color discrimination are localized. Diabetes has emerged as an increasingly important cause of blindness with the longer survival of juvenile and maturity-onset diabetics. Similarly, the increased longevity of our population has left elderly people in increasing numbers prone to degenerative vascular diseases, which can have deleterious effects on vision.

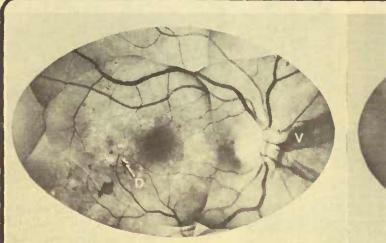
The management of the vascular complications of diabetes and of aging has always been and remains unsatisfactory. While diabetics who are able to accomplish and maintain excellent control are generally less prone to vascular complications, these complications may occur in individual instances despite the most meticulous control obtainable. Hence, diverse supplementary forms of management, including the administration of allegedly deficient vitamins and hormones, the administration of capillary "strengtheners" or anticoagulants, and the performance of pituitary ablation by various methods, have enjoyed transient popularity over the years.

Pituitary ablation is a validated mode of therapy for the accomplishment of arrest or regression of diabetic retinopathy. However, satisfactory results are achieved only in approximately half of the patients who undergo this radical procedure. Because of the numerous side effects of pituitary ablation, enthusiasm for this form of therapy has, understandably, been restrained.

Principles of photocoagulation

The advent of practical photocoagulation for the treatment of retinal vascular diseases has introduced a totally new mode of therapy. Initially utilizing the intense white light of a

Dr. Rosen is Professor and Head, Department of Ophthalmology, Queen's University and Kingston General Hospital, Kingston, Ontario.



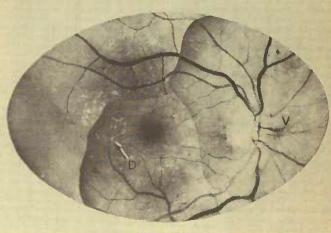


Figure 1: Diabetic retinopathy. New blood vessels (V) extend into vitreous, and diabetic changes (D) are seen adjacent to the macula.

Figure 2: Regression of the new vessels (V) after laser treatment, and partial clearing of diabetic retinopathy (D).

xenon arc and, more recently, a variety of lasers, it has become possible to selectively coagulate and obliterate retinal blood vessels judged to be at fault in producing visual deficit or to be capable of bringing about visual problems.

All forms of photocoagulation use the same principles. They incorporate an ophthalmoscopic system through which blood vessels can be visualized and subjected to a transient high temperature that results in their overheating, coagulation, closure, and subsequent replacement by scar. Fluorescein angiography has been a valuable adjunct to photocoagulation, since it provides a method of precisely visualizing retinal and choroidal blood vessels and identifying those which are abnormally permeable.

Among the modalities for photocoagulation, the most sophisticated available at this time makes use of laser energy generated with the use of the inert gas, argon. Because of its blue-green color, the argon laser beam is especially absorbed by hemoglobin. This allows the coagulation of retinal blood vessels with minimum damage to the surrounding retina.

In addition, it is possible with argon laser to coagulate blood vessels that have left the plane of the retina or optic nerve and are situated in the vitreous compartment of the eye. The latter group of blood vessels has not been susceptible to management with photocoagulation devices heretofore available.

Figures 1 and 2 illustrate the pretreatment and posttreatment appearances of the optic nerve and macula of the right eye of a 35-year-old diabetic patient who had experienced recurrent vitreous hemorrhages. Note the regression of the blood vessels originating in the optic nerve head and extending into the vitreous after treatment by argon laser coagulation, along with regression of other indicators of diabetic retinopathy (D) adjacent to the macula.

#### Macular degeneration

A range of disorders known collectively as "macular degeneration" occurs in middle-aged and elderly people. A great leap forward in the understanding of these disorders occurred with the application of fluorescein angiography to the investigation of patients with macular degenerations.

A considerable number of these patients are found to have diseases of the underlying choroidal circulation either at or adjacent to the macula. These diseases allow the exudation of fluid under the retina, thus interfering with its function. If severe enough, frank hemorrhage can occur beneath and into the retina. The resultant scarring leads to the abolition of macular function and central vision. When the abnormal vessels are identified and are found to be sufficiently distant

THE CANADIAN NURSE 37



Figure 3: Fluorescein angiogram in patient with retinal vein occlusion, illustrating irregular and leaking capillaries (C).



Figure 4: Fluorescein antiogram after laser treatment, illustrating obliteration (O) of previously leaking vessels.

from the central part of the macula (fovea), precise photocoagulation utilizing argon laser energy can have dramatic and highly beneficial effects.

Laser photocoagulation can be applied with a precision not obtainable with the xenon arc apparatus available in earlier years. In addition, it is possible to treat much closer to the center of the macula with safety. Laser photocoagulation is, accordingly, a significant advance in the management of defined forms of a senile macular degeneration.

Occlusive vascular diseases involving the arterial and venous circulation of the retina are commonly followed by the development of shunt vessels, which have associated with them abnormal retinal capillaries. These shunt vessels develop in the attempt to revascularize ischemic areas of the retina. The shunt vessels and their associated capillaries are much more permeable than normal retinal vessels. When they are situated in the vicinity of the macula, edema of the latter structure with deterioration of its function may follow.

The blood vessels can be shown up dramatically with fluorescein angiography. When treated with argon laser photocoagulation, many of the leakage points can be sealed, and the related macular edema can be reversed. At

times, there is a remarkable return of function when irreversible damage has not already taken place.

Figure 3 is a fluorescein angiogram of the macular area of the right eye of a 37-year-old female patient who, at the time of examination, had had visual decline to the level of 20/100 for almost one year. This was due to effects of occlusion of a branch of the central retinal vein. Irregular capillaries (C), which leak fluorescein, are seen. After treatment by argon laser, the leaking capillaries were obliterated (O) and the vision improved to 20/30 (Figure 4).

#### Continued study needed

The availability of photocoagulation and, most particularly, argon laser photocoagulation makes it possible to help patients who have visually-disabling vascular diseases in instances where this was not heretofore possible.

The ultimate place of this modality of therapy remains to be determined. It is still too early in its history to make long-range judgments. It is not known at this time whether early gains will in fact continue. Nor do we know with certainty whether the deliberate occlusion of retinal vessels may, in the long range, be followed by other and more difficult problems.

The procedure of photocoagulation should, therefore, realistically be viewed to be in an experimental and evaluative phase at the present time. It must remain the goal to find less destructive methods of therapy and methods of prevention of the vascular diseases that photocoagulation attempts to alleviate.

# What will happen to Mr. Lang?

An instructor raises an interesting question: What happens to a patient who is brought out of his lethargy by a nursing student, when that student is given another assignment and has to leave him?

**Leslie Horton** 

When I walked into Mr. Lang's room, he was fully dressed, lying curled up in a ball with his back to the door. My first impulse was to leave him undisturbed, but for some reason I changed my mind.

"Mr. Lang."

"Huh" he snorted.

"I'm Ms. Horton."

No answer.

"Would you turn around, please?"

Slowly, without a word, Mr. Lang turned his head so he could see me; but he remained in a curled up position.

"I teach student nurses, Mr. Lang, and will be bringing some students to this hospital next week. Today, I'm learning my way around here and meeting some of the patients."

Mr. Lang's dull, expressionless eyes continued to stare at me. After a few more unsuccessful attempts at conversation, I said, "I'll probably see you again. Okay?"

"Huh."

I'd like one of the students to work with him, I thought to myself as I left the room.

This hospital admitted patients who were able to look after themselves quite well, but because of age or lack of family ties, needed general supervision. The staff was limited in number, with two or three registered nurses and a few aides to give round the clock care to 200 people. I planned to bring students here for a six-week experience, the main objective being to help them learn to develop a one-to-one relationship with a fairly healthy individual.

After I left Mr. Lang's room, I checked with the nurse on duty. 1 learned Mr. Lang had been in the hospital for two years. He could look after most of his physical needs, but because he had no close relatives, he had to live in this hospital. He spent most of his time curled on his bed and only came out of his room for his meals and bath. The nurse was pleased to hear I wanted to assign a student to

The student I selected to work with Mr. Lang was Joan Merton, an outgoing, enthusiastic young lady. She seemed to recognize people's needs intuitively, and had a special talent in helping them feel comfortable. She eagerly accepted the challenge Mr. Lang presented. Patiently, but persistently, she encouraged him to develop an interest in himself and others, and discouraged him from maintaining his state of lethargy.

It was rewarding to see him improve. A milestone was reached the day he was neatly dressed, shaved, and sitting in his room when Ms. Merton arrived. Then, a few days later, he said, "Good morning, Ms. Merton," when she

Gradually he spent more and more

walked into his room.



Leslie Horton is the pen name of a nurse author who lives in Western Canada. She has written other articles for The Canadian Nurse in the past.

time out of his room — first to walk in the hall with the student, and later to sit in the lounge with her. Some mornings he sat in the lounge waiting for her.

By accident, Ms. Merton learned that Mr. Lang had coached little league baseball in his younger days. Being a baseball fan herself, she was able to renew his interest in the sport. The baseball games on television were usually scheduled at times that Ms. Merton was off duty. Therefore, they decided that while he watched the games in the lounge at the hospital, she would watch them at her apartment. The next time she came to see him, they would compare notes. Soon Mr. Lang knew all the players of the Montreal Expo team and their batting averages.

But time passes swiftly when one is learning, and the six weeks were coming to an end. The students had been instructed to prepare their patients for the time when they would have to leave. The day before Ms. Merton left the hospital, she walked into my office. Her usually cheerful face was sad.

"Could I speak with you, please, Ms. Horton?" she asked.

"Certainly, come in and sit down," I said, gesturing toward a chair near my desk.

She began to talk the moment she sat down. "I don't know how to make Mr. Lang understand that I'm leaving, she said. "I've told him all along that I was here for six weeks. I mentioned this frequently in our conversations so he would be prepared. Then, today, I told him that tomorrow was my last day and I wouldn't be seeing him anymore. He asked why. So I explained again that I was here for six weeks and that tomorrow would be my last day. The more I tried to explain, the less he seemed to understand. He kept repeating, 'but I don't understand, I just don't understand!' He had that same dull look in his eyes that he had the first day I worked with him. Finally, I didn't know what more to say, so I left."

After talking together awhile, I promised to go with this student to see Mr. Lang in the morning. But what help could I be? What could I say to him? How could I explain that although

he still needed Ms. Merton, we no longer needed him and therefore were leaving?

I touched the student lightly on the hand. "I'll see you in the morning then," I said.

"Thanks," she said, as she stood up to leave. When she reached the door, she turned to look at me. There were tears in her eyes. "Ms. Horton, what is going to happen to Mr. Lang?" she asked.

"I don't know, Ms. Merton," I said, "I just don't know,"

For a long time after the student left, I sat at my desk. I was troubled. What was going to happen to Mr. Lang? I told Ms. Merton I didn't know, but I didn't tell her what I thought would happen to him.

I expected that, for a while, Mr. Lang would continue to shave and tidy himself in the morning. He would spend time in the lounge watching the baseball games. However, since he had no one he could share this experience with, his interest in baseball would diminish. Then, one day, he would forget to shave. This would happen more and more often as the memory of Ms. Merton slowly faded and the brief period of his life that she had shared seemed less and less real. Finally, the time would come when he would spend most of his day curled up on his bed, his face to the wall, and a dull and expressionless look in his eyes. I hoped I was mistaken, but this is what I foresaw happening to Mr.

What am I doing to patients? I use them to teach students to care for a patient as an individual. I set up the student's schedule so she can spend more time with the patient in six weeks than any nurse has spent with him in a year. The student applies the principles she has learned. She sees they are effective as the patient begins to look and feel like an individual and a person again.

At this point, I pull the props from under the patient by removing the student. He is left alone to struggle by himself or to find his way back to that state somewhere between life and death in which he had found it less painful to live.

Did I do Mr. Lang an injustice?

Would it not have been kinder to have left him as he was? Am I committing a moral wrong by using patients in this way for student teaching?

I could argue that this short period of experiencing a close, caring relationship with the student was better than nothing at all. Perhaps. Yet I wonder whether this type of reasoning is anything more than a method to soothe my conscience. I could place the responsibility on the staff. They should spend more time with the patient and take over where the student left off.

But is this being realistic or fair? As much as the staff would like to spend more time with Mr. Lang, they already have more than they can handle. They can scarcely manage to give out the medications, do the treatments, carry out the doctors' orders, and cope with the many emergencies that occur in this type of hospital. Such activities as discussing baseball with a patient or sitting in the lounge with him would be placed very low on the list of priorities.

I could argue further that the government should allow more money so a larger staff could be hired. Perhaps it should. However, this does not relieve me of my responsibility. As much as I would like to pass the burden of responsibility to someone else, I believe it rests squarely on my shoulders. I knew what the situation was like before I assigned the students. Did I believe that, like magic, there would be money and nurses available at the end of six weeks? Of course not!

The fact was I hadn't looked that far ahead when I selected Mr. Lang. My main concern was student teaching. I had neglected to think about the patient's welfare. If I had looked ahead, I could have predicted the situation that troubled me now.

The memory of Ms. Merton standing in the doorway will remain with me for a long time. And I will not soon forget her question, "What will happen to Mr. Lang?"

**MAY 1973** 

## Idiopathic edema

The author describes a syndrome that is prevalent among the female population, is rarely diagnosed, and is underestimated as a condition contributing to disorders of personality, mood, and behavior.

J.B.R. McKendry, M.D., M.Sc., F.R.C.P. (C)

Thomas Jefferson, an astute nonmedical observer of eighteenth century medical practice, has been credited with this comment: "For some forms of disease well known and well defined, medicine has found substances that will restore order to the human system; but a great mass of disease remains undistinguished and unknown, exposed to the random shot and theory of the day." Although many diseases of that day have subsequently joined the "well-known and well-defined" category, there are still some common conditions that are often missed or misinterpreted.

One such syndrome, which afflicts only women, is idiopathic edema (or metabolic, cyclic, periodic, or distress edema). This syndrome, first reported less than 20 years ago, is still underrepresented in the literature and underdiagnosed in practice, possibly because failure to demonstrate characteristic biochemical anomalies currently prejudices the recognition and "respectability" of a new syndrome.

Admittedly, idiopathic edema also suffers from being ill-defined — in both senses of that term, since many of its clinical features are nonspecific and most published definitions are in negative terms, such as "edema without demonstrable cardiac, renal, hepatic, nutritional hypoproteinemic, or "obstructive causes."

#### Definition

Some 10 years ago, having observed the course of idiopathic edema in an initial study of 34 "classical" cases,

we evolved a definition in more positive terms. This definition has withstood the test of clinical application in about 200 subsequent cases: "An inexplicable non-pitting edema, not related to menses, which fluctuates in response to posture, emotional stress, and possibly other factors, and which principally affects emotionally labile, overweight women with diabetes or diabetic diathesis between ages 20 and 60."

#### Clinical presentation

From the foregoing, we may surmise that patients with idiopathic edema symptoms are most likely to be seen by family physicians, gynecologists, psychiatrists, general internists, or endocrinologists. Also, many women who are more or less miserable from this syndrome probably diagnose their difficulties in terms of menses, menopause, "mood," or stresses of modern life, without consulting a physician.

It is of some importance, therefore, that women generally and health personnel in particular be more aware of the general characteristics of this condition. An appropriate index of suspicion and a systematic approach to diagnosis can at least explain, if not entirely relieve, the spectrum of complaints of these sometimes difficult

patients who can preempt an inordinate amount of medical and nursing services.

The typical woman with idiopathic edema is somewhat overweight, young or middle-aged, with fatigue, irritability, depression, tension, and headaches. She usually has: a history of menstrual dysfunction or gynecological surgery; a personal or family history of diabetes; or such diabetes-related stigmata as big babics, reactive hypoglycemia, precocious coronary disease, or a history of pregnancy that includes hydramnios, toxemia, or late fetal death.

The patient may or may not spontaneously complain of swelling or puffiness. To elicit this vital clue, it is important to ask: "Are you subject to episodes of general swelling or puffiness involving face, hands, or body?" Women with simple obesity who may sometimes appear puffy will answer in the negative, while women with idiopathic edema will give a definite affirmative response.

In short, whether the examiner can appreciate it or not, women do know when they are swollen. Enquiry about this diagnostic clue should become part of every examination; for although edema is a sine qua non for diagnosis, some patients may never show visible signs of it, even though they have subjective puffiness or tightness of tissues of the limbs, face, or trunk, together with the abdominal bloating that characteristically worsens as the day goes on.

The cdema seems to occur in all tissues available to inspection, although

Dr. McKendry is Associate Professor of Medicine, University of Ottawa, and Chief of the Department of Metabolism at the Catawa Civic Hospital, Ottawa.

with change of posture there is some gravitational effect on its distribution. Even when severe, idiopathic edema characteristically is nonpitting, although some pitting may be found around the ankles from associated venous insufficiency or other cause. Presumably, internal organs share in the general edema, with involvement of the gut accounting for the abdominal distention and edema of the brain contributing to headaches and disturbance of mood and behavior.

Facial puffiness, if apparent at all, is most readily seen in the early morning, and pedal edema, in the evenings. Leg edema and foot edema are not included in our definition of the idiopathic edema syndrome, as they are too prevalent a finding in women to have much diagnostic value.

Characteristically, swellings occur intermittently, usually accompanied by exacerbation of other symptoms, mainly of central nervous system origin. The person's social history may reveal unfortunate secondary effects, resulting from the emotional lability, irritability, hostility, and depression that resemble severe and persistent premenstrual syndrome. These patients may report frequent changes of job or marital disharmony, with a greater than normal likelihood of separation or divorce.

Cigarettes and coffee were used to a greater than average degree by a majority of the women in our series. Use of alcohol, however, was not a problem, possibly because party-going often induces a troublesome exacerbation of edema and associated symptoms.

Diagnosis

Given a patient with some combination of the foregoing features, a spontaneous complaint or an evoked admission of swelling, and a reasonable index of suspicion regarding idiopathic edema, the next step is to ask her to keep a record of body weight changes for a month. She should record weight to the nearest one-half pound after

dressing in the morning, and again some 12 hours later.

Over 80 percent of women with idiopathic edema gain two or more pounds during at least one-third of the days in a month when symptoms of edema occur. This suggests that part of the mechanism of edema is exaggeration of the normal antidiuretic response to assumption of upright posture.

Our studies on control groups of women, including obese women, indieate that this magnitude of morningto-evening weight change does not occur in the absence of idiopathic edema syndrome. During more severe relapses, 8 to 10 pounds may be gained or lost in a day. Occasionally, cases are seen in which diurnal gains over several days exceed nocturnal diuresis, until this phase terminates with a spontaneous diuresis of some 8 to 15 pounds.

The possibility of hepatic, renal, cardiac, or nutritional failure as contributing factors to the edema must be excluded by appropriate tests. However, exclusion of other diagnoses does not establish a diagnosis.

To foster a positive approach to the diagnosis of idiopathic edema and to

INTERMITTENT IDIOPATHIC EDEMA CLINICAL DIAGNOSTIC INDEX	Score when present	Patient score
Nonpitting edema of face, trunk, or upper limbs, unrelated to menses.	5	
2. Weight gain 8.00 a.m. — 8.00 p.m. of 2 or more pounds on a least 1/3 of days	5	
3. Weight gain in 1 day of 4 or more pounds, unrelated to menses	4	
4. Worsening or onset of nervous tension, depression, irritability, headache in phase with edema	4	
5. History of menstrual dysfunction	3	
6. Personal history of diabetes, big babies, glycosuria, functional hypoglycemia, or repeated abortions	3	
7. Family history of diabetes or big babies (9 pounds or more)	2	
8. Nervous temperament and/or autonomic instability	2	
9. Overweight (15 percent or more over Metropolitan Life insurance tables)	1	
10. Onset 20 to 60	1	
Total Score	30	MAN 1072

help quantitate its severity, we developed a clinical diagnostic index (page 42). The weight given to various scores is, in general, based on the frequency or uniqueness of the particular clinical feature or parameter. Total scores of 15 or higher are virtually diagnostic of the idiopathic edema syndrome.

#### Neuropsychogenic manifestations

One of our earlier studies on personality characteristics and psychological changes in idiopathic edema indicated that intellectual capacity was good. This study also showed that the following were prevalent personality characteristics. "immature, demanding, and egocentric, with exaggerated needs for affection and sympathy; tendency to a hysteroid nature, usually with some secondary gain from symptoms; unduly worried about health, home, family, and financial security in that order; preoccupied with body functions and with associated multiple chronic complaints, holding fixed notions as to their organic basis; tendency to overcontrol needs and impulses, and the inability to express emotions in a modulated adaptive way; overreacts to threats or makes emergency responses in the absence of real dangers; usually reasonably capable of appropriate social behavior and able to get along with others when this is sufficiently desired; minimal schizoid or psychopathic features."

Although many women with idiopathic edema recognize they are difficult to live with, particularly during relapses, they find it virtually impossible to moderate the tenseness, depression, hostility, and aggressiveness that mar interpersonal relationships. They commonly complain that they "yell at the children constantly," "lose friends by picking fights," and "wonder how my husband puts up with me." Indeed, the morbidity resulting from edema-related disturbances of mood, personality, and behavior constitutes the most serious clinical aspect.

Even the fabled forbearance of health professionals can be exhausted by persistent termagancy (a term more elegant than "bitchiness"). Some have been described as patients "whom nurses dislike having to care for," and who are capable of "kindling feelings of aggression in the most urbane physician." But all are by no means termagantish, and only a few are persistently so — although extra efforts to maintain equanimity may be required.

#### Relation to diabetes

The second most significant clinical aspect of this syndrome is its apparent association with diabetes. For well over a decade we have been collecting information about the co-occurence of these conditions. As we follow up our not-yet-diabetic patients, we find a high rate of development of diabetes. This leads us to believe we may soon be able to replace the term idiopathic with diabetic. Although the diabetes usually develops years after the first appearance of the edema, the reverse sequence also occurs quite frequently.

The natural history of idiopathic edema is still not well known, but our experience suggests that it usually lasts a few years and rarely a few decades, and that it infrequently persists beyond age 60. The syndrome per se does not appear to reduce life expectancy; nor is it related to later development of renal disease or any other disorder except diabetes.

#### Management

Most women with idiopathic edema are greatly relieved when the diagnosis has been made and the nature of the condition - which has plagued them and often puzzled the doctor - has been explained. This provides the basis for understanding and acceptance of the problem by patient and family alike.

Lacking any clear answers to questions about even the elementary aspects of pathogenesis, there is no basis for specific therapy at this time; treatment is essentially symptomatic and supportive. The edema is tackled by weight reduction where indicated; by sodium restriction of moderate degree; and by use of diuretics, usually of the thiazide or aldosterone antagonist types. Tension, insomnia, depression, headaches, and so on, are treated by sedatives, antidepressants, and analgesics as indicated.

During exacerbation, fairly frequent follow-up visits can provide useful supportive psychotherapy and the opportunity for adjustments to the regimen of symptomatic therapy. Because of the liability to develop diabetes, blood sugar monitoring is indicated at intervals.

#### Summary

The idiopathic edema syndrome is rather prevalent among the female population, but is under-diagnosed and under-estimated as a condition contributing to significant disorders of personality, mood, and behavior. There is considerable evidence that it is somehow related to diabetes.

The usual presentation and course of the constellation of clinical features has been described, together with a systematic approach to establishing the diagnosis on the basis of clinical data. On the grounds of its capacity to produce morbidity as well as the possible insights to be derived about diabetes from better understanding of idiopathic edema, this condition deserves wider appreciation and more intensive investigation.



## dates

#### May 14-15, 1973

Interdisciplinary conference on "Understanding and Helping Families in Modern Society," Delaware Hall, University of Western Ontario, Conference fee: \$30. For further information, write to: Alumni Committee, Faculty of Nursing, Health Sciences Centre, U. of Western Ontario, London, Ontario.

#### May 18-19, 1973

Two-day conference on "Sexuality: The Professional and the Client," sponsored by Continuing Nursing Education, State University of New York at Buffalo, Schrafft's Motor Inn, Niagara Falls, N.Y. For additional information, write to: Dept. of Continuing Education, School of Nursing, State U. of New York, Buffalo, N.Y. 14216, U.S.A.

#### May 22, 1973

Association of Nurses of Prince Edward Island, annual meeting, Charlottetown, P.E.I.

#### May 27-29, 1973

Manitoba Association of Registered Nurses, annual meeting and diamond jubilee, Red Oak Inn., Brandon, Man.

#### May 29-30, 1973

Seminar on "Engineering in Health Care," sponsored by the Canadian Medical and Biological Engineering Society, Chateau Laurier Hotel, Ottawa. Registration fee: \$20. For further information, write to: Seminar Secretariat, Bldg. M-50, National Research Council, Ottawa, Ontario K1A 0R8.

#### May 29-31, 1973

New Brunswick Association of Registered Nurses, annual meeting, Hotel Beausejour, Moncton, N.B.

#### June 4-5, 1973

Course on "Production of Audiovisual and Television Resources." Fee: \$40. For further information, write to: University of British Columbia Health Sciences, Vancouver, B.C.

#### June 10-13, 1973

Third annual Canadian Educational Communications Conference, sponsored by the Canadian Education Media Council, Hyatt Regency Hotel, Vancouver. For further information, contact: Wayne Blair, Douglas College, Box 2503, New Westminster, B.C.

#### June 13-15, 1973

Saskatchewan Registered Nurses' Association, annual meeting, Corona Motor Hotel, Yorkton, Saskatchewan.

#### June 13-15, 1973

Registered Nurses' Association of Nova Scotia, annual meeting, Mount Seton Academic Centre, Mount Saint Vincent University, Halifax, Nova Scotia.

#### June 14-15, 1973

Course on "Nursing Supervision" for nurses in middle management positions. Fee: \$30. For further information, write to: University of British Columbia Health Sciences, Vancouver, B.C.

#### June 14-16, 1973

Course on "Clinical Application of Sexuality in Nursing," U. of Victoria, Victoria, B.C. For further information, write to: Registered Nurses' Association of British Columbia Continuing Education Listings for Nurses, 2130 W. 12th Ave., Vancouver, B.C.

#### June 11-15, 1973

Health care evaluation seminar, sponsored by McGill University School of Nursing. The seminar is one of a series being held across Canada. Each applicant will be asked to submit a proposal for health care evaluation, to serve as a focus for his activities during the program. Tuition fee: \$100; some scholarships and travel awards are available. For further information and application forms, write to: Moyra Allen, Project Director, School of Nursing, McGill University, 3506 University St., Montreal 112, Quebec.

#### June 11-15, August 27-31, 1973 February 18-22, 1974

One week course for nurses involved in prevention, control, and management of tuberculosis. The course, to be held in Ottawa, will be sponsored jointly by the University of Ottawa School of Nursing and the Canadian Tuberculosis and Respiratory Disease Association. For further information, write to: Ms. Lorette Morel, CTRDA, 345 O'Connor Street, Ottawa, Ontario K2P 1V9.

#### June 16, 1973

Reunion of all graduates, and 25th anniversary of the opening of the Metropolitan (Demonstration) School of Nursing, Holiday Inn, Windsor, Ontario. For further information, write to: Violet M. Burchell, 98 Beechwood Cres., Fredericton, N.B.

#### June 24-27, 1973

Canadian Tuberculosis and Respiratory Disease Association, 73rd annual meeting; Canadian Thoracic Society. 15th annual meeting and 10th annual nurses' institute, Palliser Inn. Calgary. Alberta. For further information, write to: Mr. H.E. Drouin, Executive Secretary, CTRDA, 345 O'Connor St., Ottawa.

#### July 16-18, 1973

Second national summer working conference, The American Society of Childbirth Educators, Philadelphia, Pennsylvania. Conference "Childbirth Education: Crisis Intervention." For further information, write to: American Society of Childbirth Educators, 19K-230 Riverside Dr., New York, N.Y. 10025.

#### July 16-August 3, 1973

Workshop on "Psychological Concepts of Human Sexuality as they Influence Family Planning and Sex Education," Loyola of Montreal, Summer School. Fee: \$100. For further information, write to: Ms. G. Lennox, Program Coordinator for Health Education. Loyola Evening Division, 7270 Sherbrooke St., W., Montreal 262, P.Q.

#### 44 THE CANADIAN NURSE

## new products

Round mammary prosthesis

Dow Corning has introduced a new silicone mammary prosthesis that is round in shape. Its soft, seamless envelope contains a low viscosity, translucent silicone gel that closely approximates the softness, fluid-like mobility, and weight of the normal breast. Description and instructions for its use are given in Dow's bulletin 51-194.

are given in Dow's bulletin 51-194.

The shape of the new prosthesis makes it anatomically adaptable for cosmetic augmentation mammaplasty, replacement following the removal of another prosthesis, or restoration following subcutaneous mastectomy. The seamless, soft envelope helps eliminate edge palpability of the implant. The medical grade silicone materials provide an extremely pliable implant that conforms to the desired surgical pocket and the overlying tissue. It will retain its original softness, will not harden or undergo physical alteration after implantation, and will resist absorption and degeneration.

Two versions of this Silastic prosthesis are available: one has Dacron net tissue fixation patches on the back of the implant, which allows positive fixation of the prosthesis to the chest wall by tissue ingrowth through and around the patches; the other has a single orientation patch to help establish the desired alignment. Tissue ingrowth or fixation does not occur because there is no exposed Dacron.

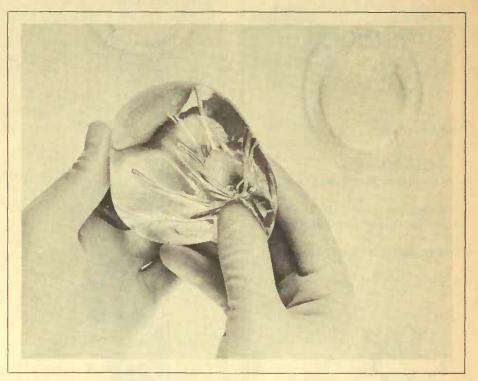
For more information, write to Dow Corning Silicones Inter-America Ltd., 1 Tippet Road, Downsview, Ontario.

Pain-relieving gas mixture

A gas mixture of 50/50 nitrous oxide and oxygen, known as Entonox, has been introduced in Canada by Canadian Oxygen Limited. Developed by the British Oxygen Company, it has been used for many years in the United Kingdom, primarily as an analgesic in childbirth.

Cylinders of the gas mixture can be self-administered by the accident victim at the scene of an accident, on the way to hospital, and in other emergencies. The units weigh  $13\frac{1}{2}$  pounds each.

According to Canox medical division, the main advantage of Entonox is that trained ambulance personnel can supervise self-administration, which involves turning on the gas and



Mammary Prosthesis



Entonox Gas Mixture

**Next Month** 

### The Canadian Nurse

- Outpost Nursing in New Brunswick
- Occupational Health Nursing at a Large Department Store
- Delusions That Trap Nurses



Photo credits for May 1973

Canadian Press, p.10

Dept. National Health & Welfare, Ottawa, p.16

Nova Scotia Communication & Information Centre, Halifax, p.20

University of Alberta Hospital, Edmonton, cover photo, pp.27-32

Queen's University, Kingston, Ont., pp.37-38

Julien LeBourdais, Toronto, p.39

### new products

breathing through a face mask or mouthpiece; a minimum of supervision is required. Analgesic and resuscitative properties are combined in one gas.

Entonox also gives quick pain relief without masking signs or symptoms when the patient reaches hospital. With the 50 percent oxygen content, there is no risk of asphyxia. Patients who have lost blood can benefit.

More information is available from Canadian Oxygen Limited, 355 Horner Ave., Toronto 14, Ontario.



**Bandafix** 

ICN Canada has introduced Bandafix, a seamless elastic 'net' bandage. It is made of spun latex threads and twined cotton to replace hydrophilic gauze and adhesive plaster. It is particularly useful to secure dressings in places that otherwise are difficult to bandage.

Bandafix is easy to use and saves time when applying, changing, and removing bandages. It stays securely in place, and comes in seven sizes to provide a fixation bandage for every part of the body. The same bandage may be used repeatedly; it is washable and can be autoclaved.

This bandage is available in clinic packages of 25 meters per size. The handy roll box can be used alone, or can be placed in the chromium-plated dispenser supplied at no extra cost.

For more information, write to ICN Canada Ltd., 675 Montée de Liesse, Montréal 377, Quebec.

Intravenous product

ICN Canada has announced a new intravenous product called ECWaSol. It is an extracellular water solution to replace extracellular water lost during and after elective operations or accidental injury, other trauma or general shock; and to administer packed cells during blood transfusion.

Since ECWaSol contains bicarbonate it can be offered in most situations where normal saline and/or its substituted lactate, acetate, and other derivatives would be used. ECWaSol is packed in 500 ml intravenous bottles.

More information is available from ICN Canada Limited, 675 Montée de Liesse, Montreal 377, Quebec.

**Epistaxis** catheter

The double balloon epistaxis catheter has been designed specifically for control of nasal hemorrhage. This catheter is easy to operate, and features total control and minimal discomfort to the patient.

The instrument is passed through one nostril until the catheter tip reaches the postnasal wall. The fixed distal balloon is inflated with a hand syringe to the desired size. The mobile proximal balloon is then moved axially along the catheter until it is within the nasal vestibule. At this position it is inflated, offering instant control of nasal hemorrhage.

The balloon is made of pure latex and is supplied sterile, ready for use. For further information, write to Herman Krone, American Hospital Supply (Canada) Limited, 1076 Lakeshore Road East, Mississauga, Ontario.

Snack tray

American Hospital Supply Corp. (Canada) Ltd. has introduced a practical snack and nourishment tray. It is  $7\frac{1}{2}$ x 10 inches in size, with an 8 oz. insulated bowl permanently molded onto it. Four Dinet trays fit onto a 15 x 20 inch or 16 x 22 inch tray. The three colors are meant to pep up lagging appetites.

According to the company, it is ideal for late meals, liquid meals, snacks, feeding between meals, and the lighter meal of a four or five-meal plan. The tray has a disposable lid.

For further information, contact Herman Krone, American Hospital Supply, 1076 Lakeshore Road East, Mississauga, Ontario.

### names

New faculty members in the school of nursing, University of Calgary, have been announced.





Marjorie Anderson

Marjorie C. Anderson (R.N., B.Sc., U. of Alberta; M.N., U. of Washington, Seattle) has taught at the school of nursing, Medicine Hat General Hospital and has been staff nurse, head nurse, and supervisor of the intensive care unit at the Royal Alexandra Hospital, Edmonton. She has also worked as a staff nurse at St. Mary's Hospital, Paddington, England.

Sheila B. Embury (R.N., Calgary General H.; B.Sc., U. of Alberta) has taught at the school of nursing, The Calgary General Hospital; has been staff nurse at the Vancouver General, Royal Alexandra, Foothills and Peace River Municipal Hospitals; municipal nurse employed by the town of Swan Hills, Alberta. She has held a number of offices with the Alberta Association of Registered Nurses.





Norma Karlinsky

**MAY 1973** 

Peggy Webb

Norma Karlinsky (R.N., Winnipeg General H.; Cert. Psych. Nursing, Allan Memorial Inst., Montreal; B.N., McGill U.) has held a variety of positions at the Allan Memorial Institute of Psychiatry, including team leader, assistant head nurse, and clinical instructor. She recently lived on a kibbutz in Israel and studied Hebrew.

M. (Peggy) R. Webb (R.N., Winnipeg General H.; B.N., U. of Man.) has

been public health nurse with the Manitoba Department of Health and Montreal Health Department; staff nurse at the Winnipeg General Hospital and the Victoria General Hospital; and has taught in the schools of nursing at the Winnipeg General Hospital, the Calgary General Hospital, and St. Joseph's school of nursing, Hotel Dieu Hospital, Kingston, Ontario.

Margaret Hardy, senior nursing consultant, occupational health services of the Ontario Ministry of Health, Toronto, was elected a vice-president of the Permanent Commission and International Association of Occupational Health at its meeting in Buenos Aires. With headquarters in Milan, Italy, this association will hold its next triennial conference in 1975 in Brighton, England.

Jo Brazel, a third-year student in the B.Sc.N. program at Mount St. Vincent University, Halifax, was elected national chairman of the Canadian University Nursing Students Association at its annual conference in Halifax. She is the official representative of CUNSA to the International Council of Nurses congress in Mexico City.

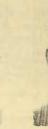
Atlantic, Quebec, Ontario, and Western regional chairmen elected are: Glenda Doucet, Dalhousie U.; Jackie Bayreuther, McGill U.; Vicki McGuire, Laurentian U.; and Gerri Trerise, U. of British Columbia.

Brenda Marion Allt is now director of nursing service, Halifax Infirmary. She is a graduate in nursing of St. Mary's Hospital, Portsmouth, England; has a diploma for teaching in schools of nursing from Dalhousie U., Halifax; and a B.Sc.N. from Mount St. Vincent U., Halifax.

Her career, since she and her husband came to Canada in 1957, has included case room work and teaching of obstetrics and medical-surgical nursing at the Halifax Infirmary.

Ms. Allt has been a member of the RNANS committee on nursing education and is currently on the Canadian Testing Service blueprint subcommittee on obstetrical nursing.







Winnifred Sutherland

Sutherland

Winifred McLean Sutherland and her surgeon husband, Dr. William Sutherland, have left for Solo, Indonesia, to serve for two years with MEDICO, a service of CARE. Their 18-year-old daughter, Mary Jane, has accompanied them.

Born in Vancouver, Ms. Sutherland attended the University of British Columbia from 1936 to 1938 and trained in nursing at the Royal Columbia Hospital in New Westminster, B.C. She met her husband during World War II while a nursing sister in the Canadian army medical corps. After her marriage, she returned to UBC to earn her B.A. and B.S.W. She has been matron in a boys' industrial school in Vancouver and, more recently, she resumed studies at UBC, majoring in theater set and costume design.

The expanded program in Solo now includes teaching of medical students at nearby universities; training of surgical nurses and personnel to offer physiotherapy, x-ray service, and so on; and a general upgrading of laboratory and hospital services.

Carole Ross (R.N., Royal Victoria H., Montreal; B.N., McGill U.) has been appointed assistant director of nursing, children's services, Douglas Hospital, Verdun, Quebec.



Ms. Ross has been on staff at the Allan Memorial Institute and has taught at Vanier College in Montreal. While on scholarship from Vanier College in 1972, she worked with the director of

education at Boston, Mass.

McLean's Hospital,

### books

Decision Making in the Coronary Care Unit by William P. Hamilton and Mary Ann Lavin. 150 pages. St. Louis, Mosby, 1972.

Reviewed by Jane K. Lenhardt, Faculty of Nursing, University of Western Ontario, London, Ontario.

This is a workbook of problems to sharpen the decision-making skills of coronary care nurses. Each chapter presents six to ten cases — real situations the authors were confronted with in a coronary care unit. They explain the actions they took in each situation, and why they were taken, not as a directive on how to handle any one situation, but to stimulate thought on

the part of the reader.

The book has nine chapters; the first seven present a type of problem frequently encountered in the coronary care unit. Each problem is approached from a patient-centered point of view, as one would gather from the chapter headings that begin "Care of the patient with. . . ." The problems discussed are: cardiac pain, an irregular pulse, a fast pulse, a slow pulse, a transvenous pacemaker, low blood pressure, and shortness of breath.

Chapter eight is entitled "Sudden Death," and examines some nonmedical aspects of this problem, as well as the more usual medical responsibilities. Chapter nine, "Practical Exercises,"

includes 60 varied situations.

The book is well organized for its purpose. Each chapter begins with a brief discussion of a problem. Each clinical situation includes a short background to the case, a short description of the situation at the time the problem arose, and a rhythm strip. Each case is

no more than two pages.

The clinical situations are quite varied. Patients with cardiac histories, as well as those with no history of cardiac disease, are included. The differences in the treatment of these two kinds of patients, even when they have the same problem, are carefully pointed out. Many of the clinical situations lead the authors to emphasize the importance of relieving the anxiety of a patient with cardiac problems — something worth emphasizing.

A few of the comments on the clinical situations presented should be taken with caution. The authors con-

sider certain actions to be nursing responsibility, although a reader's hospital might regard them as medical responsibility. The authors mention that legal clarification might be needed concerning some aspects of care, by the reader in her particular situation.

There is an error on page 106 (clinical situation number 4). The ECG rhythm strip is interpreted as ventricular bigeminy. It is, rather, nodal bigeminy—the premature beats are of junctional origin, as indicated by the P wave in the ST segment. Treatment with Lidocaine is contraindicated. It could, in fact, cause block.

This book is designed to be used as a teaching tool in the coronary care unit; as such the authors have done a fine job. Advanced nursing students, registered nurses in general practice, and instructors will also find it useful.

Cookbook for Diabetics and All the Family, 2ed. 169 pages. Don Mills, Ont., Burns & MacEachern, 1972. Reviewed by Marilyn Steels, Lecturer, McMaster University School of Nursing, and Mary Henley, Assistant Director, Department of Nutrition Services, McMaster University Medical Centre, Hamilton, Ontario.

This book is a valuable revision of the *Cookbook for Diabetics* published in 1963. The change in the book's title reflects a new emphasis on the philosophy that a diabetic diet is simply a well-balanced controlled diet. The diabetic family member need not be isolated from the rest of the family in the psychosocially important activity of eating.

The format of this revision is essentially unchanged. However, the use of plain type may enhance its readability for persons with decreased visual acuity due to retinopathy. The one major fault of the book is its lack of an index to individual recipes. Considerable page-flipping might be required to find clam chowder under "For the Gourmet" instead of "Soups."

Most diabetics on controlled diets are taught the exchange list system for meal planning. With knowledge of the number of servings a recipe should yield and the number of exchanges from each list per serving, a diabetic can safely include any food in his diet.

The cakes, cookies, and quick breads section reflects a realistic use of sugar—something new in this edition of the book. The inclusion of a wide variety of sandwich fillings and cookies should help make lunch box menus more interesting. The recipes for hors d'oeuvres, exchange list values for popular nibble foods, and numerous party suggestions should make entertaining easier and more enjoyable. All family members, young and old, can enjoy such treats as fudge, milk shakes, and ice cream floats.

In addition to recipes for many foods that diabetics have traditionally considered to be forbidden, this book includes recipes for many dishes that diabetics may have felt were too complicated to prepare safely within the limits of their diet. A comprehensive gourmet section tells the diabetic exactly what he is getting in terms of exchanges when he prepares gourmet delights, such as crab fondue, and coq au vin. Particularly valuable is the inclusion of a good selection of dishes to please families of various ethnic origins. German sour red cabbage, Ukrainian borsch, and French Canadian tourtière are but a few examples.

Although this book employs artificial sweeteners in many recipes, the tips on freezing, canning, and preparation of such things as salad dressing should help minimize the diabetic's use of special dietetic foods. This will cut down on expense and make the diabetic's diet more acceptable as general family fare. It should also minimize problems related to indiscriminate use of prepared dietetic foods, which many diabetics assume are appropriate without really knowing

what they contain.

Other features that make this book a useful basic cookbook for anyone, diabetic or not, are a section on the use of recipes, measurement techniques, abbreviations, and equivalent measures; tips on sodium and fat restriction; suggestions for the preparation of liquid and soft diets for use in illness; suggestions for the care and handling of meat, fish, and poultry; and a comprehensive section on seasonings, sauces, and stuffings.

In sum, this excellent new book

lives up to its new name. It is a cookbook for the whole family and as such should be acceptable in any diet-conscious household, with or without a diabetic family member.

Nutrition and Its Disorders by Donald S. McLaren. 280 pages. London, Churchill Livingstone, 1972. Canadian Agent: Longmans, Don Mills,

Reviewed by Elizabeth Lambie, Lecturer in Nutrition, School of University, Nursing, Dalhousie Halifax, Nova Scotia.

This small, inexpensive paperback is highly recommended for the libraries of schools of nursing. It would also assist students in medical school.

Nutrition touches many parts of medicine in varying degrees and should be part of the curriculum in physiology and biochemistry, pathology, pediatrics, internal medicine, obstetrics, and, of course, in community medicine or public health.

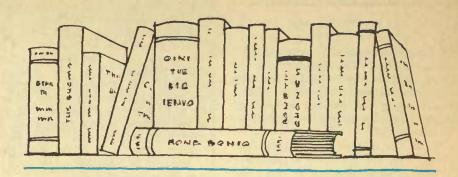
The text is divided into four sections to follow these needs: normal nutrition, primary nutritional disorders (under and overnutrition), secondary nutritional disorders, and community nutrition. In discussing systemic nutritional disorders, the author covers the liver; the intestines; diabetes mellitus; disorders of lipid, purine, amino acid metabolism; the endocrine system; the cardiovascular system; the renal system; blood; nervous system; skin; eyes; and teeth.

There is good discussion on nutrition and other conditions, such as allergy, pregnancy, injury, alcoholism, and cancer. Special mention should be made of the forward thinking section on parenteral nutrition. "... the starving patient presents a problem no less important than patients with such conditions as acute cardiac, pulmonary or renal failure. The great attention given to maintaining fluid and electrolyte balance has tended to obscure the need to supply energy and nutrients."

The author uses the agent-host-environment concept throughout; its application to the last section, nutrition

in the community, is unique.

This book is published in the United Kingdom and naturally uses the recommended daily intakes of energy and nutrients for the U.K. If we are teaching and practicing in Canada, it is advisable to use the recommendations of the Canadian Dietary Standard. It has been demonstrated that Canadians can be satisfactorily nourished on far lower intakes of protein than those suggested on page 88. There are too many people in our society who are not affluent, and protein is our most expensive food



commodity. A copy of the *Dietary* Standard for Canada is available from Information Canada bookstores.

Hypervitaminosis D is discussed; it was a frequently reported condition following World War II when a wide range of foods was fortified with vitamin D in Great Britain. Other countries have learned from this over-exuberance. Today in Canada, under law, only margarine, milks, and formulae products are allowed to have vitamin D supplementation, making it impossible for a Canadian to receive too much from food.

Perhaps the introduction of wider information on nutrition and the inclusion of this small text would help Canada to get on the bandwagon for correct nutrition information.

Operations Research in Hospitals: Diagnosis and Prognosis by David H. Stimson and Ruth H. Stimson. 110 pages. Chicago, Hospital Research and Educational Trust, 1972.

In this book the authors seek to answer two questions: What does the operations researcher have to offer hospitals at a time when mounting criticism is forcing hospital and health care administrators to seek new ways of improving services? What relationship between the operations researcher and the administrator is desirable if operations research studies in hospitals are to be useful and implemented success-

The authors assess the accomplishments and shortcomings of operations research in hospitals over the past 20 years. They acknowledge that the studies cited in the book are primarily those published in professional journals

and books.

After reviewing the operations research studies, the authors discuss some of the reasons for difficulties in implementation of study findings, such as the omission of the doctor or the patient from hospital studies and the failure to assess the complexities involved in applying computer-based technology in the hospital.

The final section of this short book deals with factors affecting the relationship between operation researcher and hospital administrator, and some sug-

gestions for changing the relationship.

This book will be valuable in the library of hospitals or other health care agencies that are involved with operations research. It is of general interest to nurses with administrative responsibilities or students in graduate programs in nursing.

Research Planning and Action for the Elderly, edited by Donald P. Kent, Robert Kastenbaum, and Sylvia Sherwood. 569 pages. New York, Behavioral Publications, Inc., 1972. Reviewed by Moyra Allen, Professor of Nursing, and Margaret Hooton, Assistant Professor of Nursing, McGill University, School of Nursing, Montreal, Quebec.

This book is a collection of 31 papers presented or developed by one or more persons associated with research, planning, or action for the elderly. In the introduction, the authors contend that the present level of knowledge of the elderly is an inadequate base from which direction can be taken to provide services for the elderly. They also acknowledge that the practitioner is under pressure to solve problems and

Their proposed solution to this bind is the adoption of an action-research framework that would bring theory, practice, and research together in a type of process research whereby treatment process is linked to outcome goals. They take a look at the whole field of social gerontology and suggest research strategies. necessary

### books

"Adequate avenues of implementation" would include the development of generalized theory, specific research strategies, communicative systems, and links among the various individuals engaged in separate but complementary activities.

With this as their focus, they proceed to examine the world of the elderly in three parts: focus on theory, principles, and broadest use of social research and social action; focus on research strategies and techniques; and focus on studies, substantive findings, and research reports with implications

for practice.

In their discussion of the theoretical approaches, they attempt to present an interdisciplinary perspective. In their desire to do this, they include such a variety of viewpoints that one has difficulty holding them in order to assess them. At the same time, the authors do not suggest a method for doing this, except in the social sciences. The final chapter of the first section is devoted to a consideration of the social science theories in terms of the authors' research-action viewpoint. However, to approach the study of the elderly from an interdisciplinary perspective, one might have expected that other sources would be included, such as biologists, novelists, and other observers of the aged, for example, Simone de Beauvoir.

The discussion of research strategies and techniques provides the reader with ways to gain information and data on the problems of the aged. Since this field of study is in its infancy, one is not surprised to note the scattering of research techniques presented. This same factor may account for the noncritical approach adopted toward research methods. Some of the specific aspects of the elderly about which questions are asked, include: competence, social adjustment, interviewing behavior, greeting behavior, and projective techniques. Certainly these areas of investigation reveal data, but one would anticipate that, as this area of knowledge develops, the problems of the aged would be attacked at a higher level, that is, within the context of society and culture.

When one reads some of the studies presented in the final section of the book, for example, Physical Impairments in Aging or Socialization and Social Adjustment in Five Resident Settings, one is struck by the rather simplistic notion that specific ideas of theory can be easily applied to solve a

complex social problem. As this field of knowledge continues to develop, it becomes increasingly obvious that one cannot take small bits of knowledge and build practice around them.

In the introduction to the book, the point is made that ideas arise out of practice and out of the study of a particular problem. Yet, the research techniques and studies that have been done on the aged population do not appear to have used the aged as their initial and primary source from which to derive beginning notions in this field. In other words, most of the ideas that are applied in practice stem from a given theoretical position.

Owing to the vastness of the problem and to the goals the authors set themselves, the book must provide a rather cursory overview at present. The book and, apparently, the state of knowledge of the elderly at this moment suffer greatly from the assumption that we know the problems confronting the aged person, and that we also understand how he is experiencing his situation. It is this assumption that unfortunately forms the basis for action for the most part, but the authors do not identify this as a problem.

### MOVING? BEING MARRIED?

Be sure to notify us six weeks in advance, otherwise you will likely miss copies.

Attach the Label From Your Last Issue OR Copy Address and Code Numbers From 11 Here

NEW (NAME) /ADDRESS:

Street
City Zone

Please complete appropriate category:

I hold active membership in provincial nurses' assoc.

reg. no./perm. cert./ lic. no.

I am a Personal Subscriber.

MAIL TO:

Prov./State

The Canadian Nurse 50 The Driveway OTTAWA, Canada K2P 1E2 This book represents a collection of many ideas about the aged. For the person who wishes to examine this problem in a more critical way, it will be useful as a reference. However, additional sources of data need to be used, some of which should come from developmental research studies.

### AV aids

### FILMS

Two new health films on hearing loss are available from Educational Film Distributors Limited, 191 Eglinton Avenue East, Toronto M4P 1K1.

Listen While You Can (color, 21 mins., \$290) stresses the importance of self-protection against noise. The film demonstrates the type of hearing loss sustained from working in areas of noise hazard. Sound frequency, cycle and intensity, and use of the oscilloscope in sound measurements are explained. There are also explanations of the structure of the ear, use of an audiometer and audiogram, different types of dangerous noise, and means of reducing noise that is hazardous to the worker.

Hearing Conservation (color, 22 mins., \$300) emphasizes the importance of evaluating noise before it produces hearing loss. The film suggests improvements to reduce noise

levels.

### VISUAL AIDS

"Health begins at home" is the theme for world health day in 1973, the year the World Health Organization is celebrating its 25th anniversary. The 25 best photographs on this theme from the who collection are available free of charge for exhibition or publication in 8 x 10 inch size. Duplicate negatives can be sent on request for larger sizes. The photographs are captioned on the back. Color transparencies on most subjects are also available for publication at a cost of \$10 (U.S.) per transparency for one-time reproduction. There are also 11 illustrations available. These depict the history of international cooperation in health. For more information, write to WHO, 1211 Geneva 27. Switzerland.

Castrol Oils (Canada) Limited has available a new wall poster entitled "Skin Welfare — Your Action." The poster, which is free of charge, measures 25 x 35 inches and gives information about preventing common skin com-

plaints in cartoon form. To obtain this poster, write to D.J. Weston, Coordinator, Advertising & Publicity Services, Castrol Oils (Canada) Limited, 3660 Lakeshore Blvd., West, Toronto, Ont. M8W 1P2.

TAPES ON TELEPHONE

At the 1972 American Medical Association Communications Clinic, the executive director of the San Bernardino County Medical Society in California described Tel-Med, a method of giving health care information over the public telephone system by recorded tapes. His description of Tel-Med appeared in the March 15 issue of *Channels*, published in New York by the National Public Relations Council.

There are over 100 tapes in the society's library; each runs from three to five minutes. When a person phones a number, an operator answers. If the person does not have a list of the tapes with their titles and numbers, he can ask for a tape on a topic such as heart disease. The tape is then plugged into the telephone system. When the tape is finished the line is automatically terminated.

The medical society received 21,000 calls for Tel-Med during its first four months of operation.

CLOSED CIRCUIT TV

Inservice coordinators at Halifax and Dartmouth, Nova Scotia, hospitals recently combined their talents to use closed circuit television in hospitals as a teaching aid.

Using the facilities of Dalhousie University's audiovisual department, they produced their first program, "The Nursing Team Conference." Their second program, "Problem Solving in the Nursing Process," should be completed before the summer of 1973. The tapes feature role playing by members of the inservice committee, who have functioned as a group for special projects during the past few years. These tapes are considered to be a valuable nursing instruction aid.

Another recent project of this group was a two-day workshop on progressive team leadership, specifically designed for general staff nurses in the Halifax-Dartmouth area. The program was well attended and most successful.

LITERATURE AVAILABLE

☐ The Vanier Institute of the Family has published a bilingual Catalog of Canadian Resources on the Family, which gives an annotated listing of Canadian print and audiovisual materials. The Institute plans to update the catalog from time to time.

The audiovisual material listed in the catalog includes films, filmstrips, tapes, and records. The printed material includes books, articles, periodicals, and pamphlets. Most of the resource material found here has been produced since 1965.

Divided into seven sections, the catalog contains material on the Canadian family; social policy; family living; special pressures on the family; education for family living; bibliographies and film catalogs; and addresses of the publishers, associations, agencies, companies, and other groups whose resources are listed.

For further information about this catalog, write to The Vanier Institute of the Family, 151 Slater St., Ottawa K1P 5H3. Cost of the catalog is \$2.50.

☐ The November-December 1972 issue of Public Health Currents, published by Ross Laboratories in Columbus, Ohio, was devoted to audiovisuals in health education. Included was background material, considerations in using and producing audiovisuals, factors in selecting AV hardware, and a source list of selected educational audiovisuals.

Copies of a suggested audiovisual presentation checklist can be obtained

RN.'s

## SPEEDY PLACEMENT IN SUNNY CALIFORNIA

Immediate staff positions to \$904/mo, (\$10,848.a) plus major benefits. Other openings/salary commensurate to education and experience.

U.S. entry & work permit (yearly term) obtainable within 30 days. You do not have to appear at the U.S. Consulate for your visa. Housing accommodations & relocation assistance. Airfare advanced.

Over 50 general hospitals, variety of sizes, specialties & locations.

FREE: We do all paper work, NO PLACEMENT FEE.

PROFESSIONAL NURSE RECRUITERS (Authorized Rep. of Hospitals) 1316 Wilshire Blvd., Suite 12 Los Angeles, California 90017

Tél.: (213) 481-0666 or 481-0691

Without obligation, please send me more information and an application form.

Name:
Address:
Tel.: ( )
Licenses:
Specialty:
Year Graduated: Prov

from the editor, Currents in Public Health, Ross Laboratories, 625 Cleveland Avenue, Columbus, Ohio 43216.

The Third Eye, a 34-page publication of the Ontario Educational Communications Authority, covers the basic principles of the portable videotape recorder/camera. Copies of this guide to the use of the portapak half-inch VTR are available for \$1 from OECA Publications, P.O. Box 19, Postal Station "R," Toronto 352.

☐ Also available from OECA is the VIPS Catalogue, a two-part videotape program service with more than 1,500 programs. About 800 of these programs are aimed at school audiences.

### **VIDEO NEWS**

Reading the National Film Board's Challenge for Change publication is always an eye-opener. In the autumn 1972 issue, a letter from Mike Goldberg of the Vancouver Art Gallery described some innovations in the everchanging world of videotape. For example, he described the setting up of a noncommercial, international videotape exchange directory.

Another interesting development mentioned in this letter was an informal storefront videotheater in the Japantown area of Vancouver, "where locals pay \$1 to view tapes of broadcast TV

imported from home."

The description of this Pacific videotheater continues: "A lot of activity is picking up within a two-block radius due to the advancing edge of the Gastown Tourist Development. With two information centers, two native Indians' centers, two underground papers, the Sally Ann and other evangelical chapels and shops, Intermedia, second-hand stores, Japanese restaurants and groceries, it is an ideal setting for a videotheater."

If you would like to receive this NFB communications grab bag, write to Challenge for Change, National Film Board of Canada, P.O. Box 6100, Montreal 101, Quebec.

### accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, except reference items, may be borrowed by CNA members, schools of nursing and other

### accession list

institutions. Reference (R) items (archive books and directories, almanacs and similar basic books) do not go out on loan. Theses (also R) are on Reserve and may go out on Interlibrary loan only.

Request for loans should be made on the "Request Form for Accession List" and should be addressed to: The Library, Canadian Nurses' Association, 50 The Driveway, Ottawa, Ont. K2P 1E2.

No more than *three* titles should be requested at any one time.

### BOOKS AND DOCUMENTS

- 1. Almanach du peuple; petite encyclopédie familiale publiée depuis 1869. 104. éd. Montréal, Beauchemin, 1972. 576 p.
- 2. The anesthesiologists handbook, by Donald G. Catron. Baltimore, Md., University Park Press, 1972, 158p.
- 3. Approaches to national health planning, by Herman E. Hilleboe et al. Geneva, World Health Organization, 1972. 108p. (WHO Public health papers no.46)
- 4. Les assistants médicaux; colloque du 20 avril 1971. Québec, Université du Québec, 1972? 122p. (Les Colloques de l'Université du Québec, no.3)
- 5. Background papers for Conference on Continuing Nursing Education, Vancouver, B.C., Nov. 28, 1972. Vancouver, B.C. University of British Columbia, Dept. of Continuing Education, 1972. 1 vol.
- 6. Body fluids and electrolytes; a programmed presentation, by Norma Jean Weldy. St. Louis, Mosby, 1972. 101p.
- 7. Cookbook for diabetics and all the family. 2ed. Toronto, Burns & MacEachern, 1972. 169p.
- 8. Community health centre handbook. Toronto, Wayland Workshops, 1972, 65p.
- 9. Conference planning. Edited by W. Warner Burke and Richard Beckhard. 2ed. Washington, NTL Institute for Applied Behavioral Science, 1970. 174p.
- 10. Constitution and by-laws. Karachi, Lahore, Pakistan Nurses' Federation, 1972. 77p.
- 11. Credit by examination in nursing; proceedings from a Western Regional Conference, 1972. Edited by Jo Eleanor Elliott et al. Boulder, Col., Western Interstate Commission for Higher Education, 1972, 71p.
- 12. Curriculum guides for family life and sex education; an annotated bibliography, edited by Joyce Lang. Portland, Or., E.C. Brown Foundation, 1972. 56p.
- 13. Dictionnaire des termes techniques de médecine, par Marcel Garnier et Valery Delamare. 19. éd. Paris, Maloine, 1972. 1215p.
- 14. Ear, nose and throat nursing, by Susanna

- Marshall and Zena E. Oxlade, 5ed. London, Baillière Tindall, 1972, 262p.
- 15. Eléments de génétique générale et humaine, par Jacques Ruffie. Paris, Masson, 1969, 86p.
- 16. Eléments de statistique médicale et biologique, à l'usage des étudiants en propédeutique médicale (P.C.E.M.) par Daniel Schwartz et Philippe Lazar. 4. éd. Paris, Flammarion, 1971. 144p.
- 17. Forum lectures; anthropology, by Voice of America, Washington, U.S. Information Agency, 1964? 181p.
- 18. Forum lectures; the family series, by the Voice of America. Washington, U.S. Information Agency, 1964. 16 volumes in 1.
- 19. Genetic disorders: prevention, treatment, and rehabilitation; report of a WHO Scientific Group. Geneva, World Health Organization, 1972. 46p. (WHO Technical report series no. 497)
- 20. Glossaire de psychiatrie, par Pierre Marchais, avec le concours du Conseil international de la langue française. Paris, Masson, 1970. 238p.
- 21. Guerilla television, by Michael Shamberg. New York, Holt, Rinehart and Winston 1971. 108p.
- 22. Gynaecology illustrated, by Matthew M. Garrey et al. London, Churchill Livingstone, 1972. 492p.
- 23. Harrap's new standard French and English dictionary. Rev. and edited by R.P. L. Ledésert and Margaret Ledésert. London, Harrap, 1962-1972. 2 pts in 3. R
- 24. How to divide medical words; over twenty-five thousand words in common usage showing their spellings and combinations into syllables, by Richard V. Lee and Doris J. Hofer. Carbondale, 111., Southern Illinois Univ. Press., 1972, 229p.
- 25. The management and nursing of burns, by J. Ellsworth Laing and Joyce Harvey. London, English Universities Press, 1971. 116p.
- 26. Management of the alcoholic patient. Vancouver, B.C., St. Paul's Hospital, 1972. 74p.
- 27. Methods of establishing equivalences between degrees and diplomas, by International Association of Universities. Paris, Unesco, 1970, 143p.
- 28. Notions élémentaires d'anesthésie, par P. Radiguet de la Bastaïe. Paris, Arnette, 1972. 238p.
- 30. Nous et les garçons, par T. McGinnis. Traduction de Jacques Mignon. Paris, Resma, 1971. 199p.
- 31. Le nursing; aspects fondamentaux des soins, par Marie-Claire Rheault. 5. éd. Montréal, Renouveau Pédagogique, 1973. 360p.
- 32. Nursing care of the cancer patient, by Rosemary Bouchard and Norma F. Owens. 2ed. St. Louis, Mosby, 1972. 290p.
- 33. Nursing care of the patient with gastrointestinal disorders, by Barbara A. Given and Sandra J. Simmons. St. Louis, Mosby, 1971, 271p.
- 34. Nursing skills and techniques; instructor's guide, by Crystal M. Lange and Caroline

- M. Mertz, Englewood Cliffs, N.J., Prentice-Hall, 1960-1970. 2 vols.
- 35. Nutrition of housebound old people, by A.N. Exton-Smith et al. London, King Edward's Hospital Fund for London, 1972. 68p.
- 36. Of time, tides, and inner clocks; taking advantage of the natural rhythms of life, by Henry Still. Harrisburg, Pa., Stackpole Books, 1972, 218p.
- 37. Patients, hospitals and operational research, by G.M. Luck et al. London, Tavistock Publications, 1971. 210p.
- 38. The pill; a true perspective, by James C. Paupst. Toronto, Clarke, Irwin, 1972. 106p.
- 39. Pratique médicale à l'usage infirmières, par Armand Denis Joseph Molinier. Paris, Doin, 1971. 263p.
- 40. Pregnancy, birth and the newborn baby; a publication for parents, by the Boston Children's Hospital Medical Center. New York, Delacorte, 1971. 474p.
- 41. Pre-nursing course in science, by John M. Munro, 3ed. London, Churchill Livingstone, 1972, 152p.
- 42. Proceedings of Health of the Nation Conference, Karachi, Pakistan, 21 Mar.-8 Apr. 1971. Edited by Hakim Mohammed Said. Karachi, 1971. 505p. (Hamdard medical digest v.15, no.3/4)
- 43. Report 1971. New York, The Population Council, 1972. 155p.
- 44. Les rêves, miroir de la vie, d'après Freud; notre propre sexe et le sexe opposé, maturation et transformation. Sherbrooke, P.Q., Editions Paulines, 1972. 214p.
- 45. To serve is to love: the Canadian story of the Sisters Servants of Mary Immaculate, by Sister Claudia Helen Popowich. Toronto, Sisters Servants of Mary Immaculate, 1971. 355p.
- 46. Topics; information on significant programs and issues on health care. Chicago. American Medical Association, 1972, 185p.
  47. Understanding electrocardiography; physiological and interpretive concepts, by
- Louis, Mosby, 1972, 192p. 48. Women and madness, by Phyllis Chesler. Garden City, N.Y., Doubleday, 1972, 359p.

Edwin G. Zalis and Mary H. Conover. St.

### PAMPHLETS

- 49. Air quatity criteria and guides for urban air pollutants; report of a WHO Expert Committee. Geneva, World Health Organization, 1972. 35p. (WHO Technical report series no. 506)
- 50. Document on staff development, by Patricia M. Wadsworth. Prepared for the Canadian Nurses' Association. Ottawa, Canadian Nurses' Association, 1972. 15p.
- 51. Le dossier médical, par Rollande Gagné, éditeur et Guy Pothier. Montréal, Intermonde, 1972. 43p.
- 52. International Nursing Index. Repertoire de titres français. New York, American Journal of Nursing Company, 1970. 17p. R
- 53. Organization of local and intermediate health administrations; report of a WHO Expert Committee. Geneva, World Health

Organization, 1972. 26p. (WHO Technical report series no. 499)

54. La psychiatrie dans l'hôpital général. Montréal, l'Hôpital Maisonneuve, 1972.

55. Report to House of Delegates. Des Moines, Iowa, Iowa Nurses' Association, Task Force Committee, 1972. 1 vol.

56. Sex Information and Education Council of the U.S. New York, 1967-1970. Siecus study guide no. 4 - Characteristics of male and female sexual responses.

57. Siecus study guide no. 5 — Premarital sexual standards.

58. Siecus study guide no. 6 - Sexual relations during pregnancy and the post-delivery

59. Sex Information and Education Council of the U.S. New York, 1967-1970. Siecus study guide no. 8 - Sexuality and the life

60. Siecus study guide no. 12 - Sexual life in the later years.

61. Suggested basic list of books and journals. Toronto, Ontario Medical Association, Committee on Medical Library Services, 1972. 4p.

62. The theoretical framework, diploma nursing program, by Marguerite E. Schumacher. Red Deer, Alberta, Red Deer College, 1972. 27p. (Monograph no. 2)

**GOVERNMENT DOCUMENTS** Alberta

63. Dept, of Health and Social Development.

Medical Services Division. Health careers. Edmonton, 1972, 6p.

Canada

64. Dept. of National Health and Welfare. Play for preschoolers. Ottawa, Information Canada, 1971. 50p.

65. - Report of National Conference on Health Manpower, 2nd, Oct. 19-22, 1971. Ottawa, 1972, 205p.

66. Ministry of State for Science and Technology. Scientific activities; federal government costs and expenditures 1963-64 to 1972-73. Ottawa, Information Canada, 1972.

67. Science Council of Canada. Innovation and the structure of Canadian industry, by Pierre L. Bourgault. Ottawa, Information Canada, 1972. 135p. (Its Special study no.

68. - National engineering, scientific and technological societies of Canada; background study by Allen S. West; perspectives and recommendations by the Management Committee of SCITEC. Ottawa, Information Canada, 1972. 114p. (Its Special study no. 25) 69. .... Report 1971/72. Ottawa, Information Canada, 1972, 64p.

70. Statistics Canada. Awards for graduate study and research, 1971. Ottawa, 1972.

71. - Family food expenditure in Canada, 1969. Ottawa, Information Canada, 1972.

72. Statistics Canada. Federal government

expenditures on the human sciences, 1969-70. Ottawa, Information Canada, 1972. 44p. Ontario

73. Ministry of Community and Social Services. Retirements and preparation for retirement; a bibliography and sourcebook. Toronto, available from Ontario Government Bookstore, 1972, 31p.

74. Ministry of Labour. Research Branch. Negotiated wage rates in Ontario hospitals. Toronto, 1972, 201p.

Ouebec

75. Régie de l'assurance-maladie. Rapport 1971/72. Québec, 1972, 46p.

STUDIES DEPOSITED IN CNA REPOSITORY COLLECTION

76. An analysis of home visits by public health nurses. Project 1, an exploratory study of home visits by public health nurses to patients with cardiac disorders, by Rosella Cunningham. Toronto, Faculty of Nursing, University of Toronto, 1972, 90p. R

77. The influence of a human relations laboratory on the effectiveness of third-year psychiatric nurses, by Kenneth Lloyd Checkley. Edmonton, 1971. 131p. (Thesis - Alberta) R

78. A survey to determine the perceptions of a selected group of head nurses and supervisors concerning the channels of communication existing within a hospital, by Deborah Margaret Hoeffler. Seattle, Wash., 1971. 99p. (Thesis (M.N.) - Washington) R

### **ELECTROCARDIOGRAPHY** WORKSHOP

HENRY J.L. MARRIOTT, M.D.

For nurses and interested physicians.

**JUNE 25-28.** 

Cape Cod, Massachusetts, U.S.A. —

**JULY 11-13** 

Youngstown, Ohio, U.S.A.

For further information write:

TAMPA TRACINGS WORKSHOP Box 14405 St. Petersburg, Florida 33733 U.S.A.

### THE MONTREAL **GENERAL HOSPITAL**

Invites applications from

### REGISTERED NURSES FOR GENERAL DUTY

Active Inservice Education Program. Progressive Personnel Policies.

For further information apply to:

The Director of Nursing The Montreal General Hospital 1650 Cedar Avenue Montreal 109, Quebec

### classified advertisements

#### ALBERTA

FACULTY — ASSOCIATE OR FULL PROFESSOR TO TEACH AND DIRECT RESEARCH IN NEW TWO-YEAR CLINICAL NURSING MASTER'S PROGRAM IN NURSING IN ACUTE ILLNESS. DOCTORAL DEGREE. ADVANCED CLINICAL PREPARATION AND EXPERIENCE IN THESIS ADVISEMENT REQUIRED. APPLY TO: RUTH E. McCLURE, M.P.L. DIRECTOR, SCHOOL OF NURSING, THE UNIVERSITY OF ALBERTA EDMONTON, ALBERTA, 16G 2G3. POSITION AVAILABLE IMMEDIATELY.

REGISTERED NURSES required for a 30-bed Gen-ral Hospital, salary and Personnel Policies as per AARN Location of hospital, 80 miles east of Lacom-be, Highway No. 12. For more information write or phone 882-3434, Director of Nursing, Our Lady of the Rosary Hospital, Castor, Alberta.

REGISTERED NURSES required immediately for 72-bed accredited, active treatment hospital. (Vacancies on all units) AARN — AHA contract in force. Apply: Director of Nursing, Providence Hospital, High Prairie, TOG 1E0, Alberta.

Myrnam Municipal Hospital requires 2 GENERAL DUTY NURSES. Salaries in accordance with AARN recommendations and recognition granted for past experience. Lodging available in nearby nurses residence. Excellent communication to Edmonton and other major cities. Area provides boating, fishing and golfing facilities. Apply to: Mrs. R. Marko, N/S, or phone 366-3870, Myrnam, Alberta.

### **ADVERTISING** RATES

FOR ALL CLASSIFIED ADVERTISING

\$15.00 for 6 lines or less \$2.50 for each additional line

Rotes for disploy odvertisements on request

Closing date for copy and cancellation is 6 weeks prior to 1st day of publication month.

The Canadian Nurses' Association does not review the personnel palicies of the haspitals and agencies advertising in the Journal. For authentic information, prospective applicants should apply to the Registered Nurses' Association of the Province in which they are interested in working.

Address correspondence to

# Canadian



50 THE DRIVEWAY OTTAWA, ONTARIO K2P 1E2

### BRITISH COLUMBIA

DIRECTOR OF NURSING: Applications are invited for the position of Director of Nursing for a modern fifty-six bed hospital in the Lakes District of the Central Interior of B.C. Applicants holding a degree in Nursing or a University diploma in Supervision preferable. Satisfactory administrative experience essential. Apply to: (Miss) Doris O.R. Allin, Administrator, Burns Lake and District Hospital, Box 479, Burns Lake, British Columbia.

OPERATING ROOM NURSE wanted for active mo-dern acute hospital. Four Certified Surgeons on attending statt. Experience or training desirable. Must be eligible for B.C. Registration. Nurses residence available. Salary \$687 per month starting. Apply to: Director of Nursing, Mills Memorial Hospi-tal, 2711 Tetrault St., Terrace, British Columbia.

GENERAL DUTY AND OPERATING ROOM NURSES for modern 450-bed hospital with School of Nursing. RNABC policies in effect. Credit for past experience and postgraduate training. B.C. Registration required. For particulars write to: Acting Director of Nursing Service, Victoria General Hospital, Victoria, British Columbia.

REGISTERED NURSES required for Nicola Valley General Hospital, located in the Southwestern part of B.C. Starting salary from \$672.00 to \$740.00 depending on experience. Residence available. Apply to: Director of Nursing, N.V.G.H., P.O. Box 129,

EXPERIENCED NURSES required in 409-bed acute Hospital with School of Nursing. Vacancies in medical, surgical, obstetric, operating room, pediatric and Intensive Care areas. Basic salary \$672. \$842. B.C. Registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

EXPERIENCED GENERAL DUTY NURSES — required for small up-coast hospital. Salaries start at \$672.00. Residence accommodation at \$25.00 per month. 20 days annual vacation. Transportation paid from Vancouver, B.C. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia.

GENERAL DUTY NURSE wanted for 87-bed modern hospital. Nurses Residence. Salary \$546.00 per month for BC Registered. Apply: Director of Nursing, Mills Memorial Hospital, Terrace, British Columbia.

### MANITOBA

REGISTERED NURSES are required for the following positions in a 68-bed General Hospital: Evening Supervisor, Night Supervisor, Head Nurse in Combined Medical and Surgical Ward and Pediatric Ward, and General Duty Nurses. Salaries in accordance with M.H.S.C. approved rates. For further information apply: Administrator, Ste Rose General Hospital, Ste Rose, Manitoba.

### NOVA SCOTIA

COORDINATOR OF NURSING PROGRAM required COORDINATOR OF NURSING PROGRAM required by Mount Saint Vincent University to coordinate undergraduate degree program and post R.N. program. Qualifications: M.S. or M.S.N. Effective date of appointment: July 1, 1973. Closing date for applications: when position is filled. Apply to: Sister Margaret Molloy. Academic Dean, Mount Saint Vincent University, Halifax, Nova Scotia.

### ONTARIO

REGISTERED NURSES — Let's bring our profession into the twentieth century and see that it survives to the twenty-first! VOTE Enid Harris, for Council, College of Nurses of Ontario. 781-2606. Please put this notice on your bulletin board.

OIRECTOR OF PUBLIC HEALTH NURSING for generalized programme, in a progressive Health Unit. Position requires Diploma in Advanced Public Health Nursing and Supervision. Personnel Policies include Car Expense, Omers. Canada Pension Plans. Group Life Insurance, 66-2/3% of OHIC, Cumulative Sick Leave Plan and Liberal Vacation. Apply to: Dr. C.R. Lenk, Director, Medical Officer of Health, Hastings & Prince Edward Counties Health Unit, Shopping Plaza, 470 Dundas Street East, Belleville, Ontario. K8N 1E9. This position will be available in mid Summer owing to the retirement of the present Director. DIRECTOR OF PUBLIC HEALTH NURSING for gener-

SUPERVISOR OF PUBLIC HEALTH NURSING: For progressive Health Unit, for generalized program. Nursing degree essential. Excellent personnel policies. Apply: Dr. V. Soudek, Medical Officer of Health, Leeds, Grenville and Lanark District Health Unit, Box 130, Brockville, Ontario.

REGISTERED NURSES required by 70-bed General Hospital situated in Northern Ontario, Salary scale—\$610.00—\$720.00 allowance for experience. Shitt differential, annual increment, 40 hour weak. Excellent personnel policies. For particulars apply: Director of Nursing, Lady Minto Hospital at Cochrane, Cochrane, Ontario.

REGISTERED NURSES for 34-bed General Hospital, Salary \$525, per month to \$625, plus experience al-lowance. Excellent personnel policies. Apply to Director of Nursing Englehart & District Hospital Inc., Englehart, Ontario,

REGISTERED NURSES required for a new 79-bad General Hospital in bilingual community of Northern Ontario, French language an asset, but not compulsory. Salary is \$645. to \$758. monthly with allowance for past experience, 4 weeks vacation after 1 year and 18 sick leave days per year. Unused sick leave days paid at 100% every year. Mastar rotation in effect. Rooming accommodations available in town. Excellent personnel policies. Apply to: Personnel Director, Notre-Dama Hospital, P.O. Box 850, Hearst, Ont.

REGISTERED NURSES required by a modern well-equipped hospital. Situated in a progressive Com-munity in Northern Ontario. Excellent employee benetits and working conditions. Apply to Director of Nursing, Sensenbrenner Hospital, Kapuskasing. Ontario.

REGISTERED NURSES for all units, including operating room, required for a newly expanded 65-bed hospital. Excellent personnel policies. Apply to Director of Nursing, Meaford General Hospital, Meaford Ontario. NOH 1YO.

REGISTERED NURSES with experience for 37-bed fully accredited hospital in North Western Ontario. Accommodation in nurses residence available. Apply: Director of Nursing, Nipigon District Memorial Hospital, Box 37, Nipigon, Ontario.

# The Canacian Nurse

پىرى الىne 1973 چىچ

12 JIIN 3779



Red Cross outpost nursing in the '40s staff nurse involvement in research

# Who makes surgeons' gloves for the giants of skill who are small in stature and wear size 5 1/2



Perry!...Naturally! But why? —Because small in stature doesn't mean small in the appreciation of proper fit and other features and benefits that have made Perry the most widely used latex surgeons' gloves—in any size! Like all Perry Latex Surgeons' Gloves, size 5½s have beaded wrists for added protection and strength, whisper thin palms to lessen hand fatigue, exclusive Dermashield® process that provides a durable hypo-allergenic finish and packaging to fit your preferred dispensing technique. If you'd like a sample of Perry Latex Surgeons' Gloves, please write us. By the way, you don't have to wear size 5½, we'll send you the size gloves that fit you.



AFFILIATED MEDICAL PRODUCTS LIMITED
90 Commercial Ave., Ajax, Ontario

### **CURRICULUM BUILDING IN NURSING: A Process**

This volume is directed toward the educator interested in developing a new nursing curriculum or modifying an existing one. It provides essential educational theory and then makes direct applications to the special needs of the nursing curriculum. Topics considered include: future nursing functions; learning strategies; task groups; and much more.

By EM OLIVIA BEVIS, R.N., B.S., M.A. August, 1973. Approx. 232 pages, 7" x 10", 34 illustrations in 28 figures. About \$6.75.

### A New Book!

### NURSING AND THE PROCESS OF CONTINUING EDUCATION

As a book of readings, this volume provides a convenient reference to available resources, designs, methods of implementation, learning aids, and innovations which have proved successful in continuing education programs. Each article has been carefully selected by experts, and each is preceded by an introduction which puts the material in perspective.

Edited by ELDA S. POPIEL, R.N., B.S., M.S., with 32 contributors. July, 1973. Approx. 214 pages, 61/2" x 91/2", 6 illustrations. About \$6.95

### New 2nd Edition!

Burrell-Burrell

### INTENSIVE NURSING CARE

A completely current new edition includes two new chapters: one on basic anatomy and physiology of the nervous system; the other on burns, prepared with the expert assistance of another Mosby author, Florence Jacoby. Other material covers salient points of physical examination; mechanisms of shock; new electrode placing; and central venous pressure monitoring.

By LENETTE OWENS BURRELL, R.N., B.S., M.S.N.; and ZEB L. BURRELL, Jr., A.B., M.D., F.A.C.P. June, 1973. 2nd edition, approx. 320 pages, 7" x 10", 84 illustrations, drawings by WEONA WRIGHT. About \$9.75.

### CLINICAL ASSESSMENT FOR THE NURSE PRACTITIONER

Recognizing the fact that nurses face increased responsibility for patient care, the authors provide an overview of the clinical diagnostic process. Discussions include: the essentials of patient history-taking; performing a physical examination; keeping meaningful patient records; and ordering and interpreting appropriate laboratory studies.

By WILLIAM C. FOWKES, Jr., M.D.; and VIRGINIA K. HUNN, R.N., B.S.N. August, 1973. Approx. 192 pages, 7" x 10", 36 illustrations. About \$5.75.

### A New Book!

### READINGS IN GERONTOLOGY

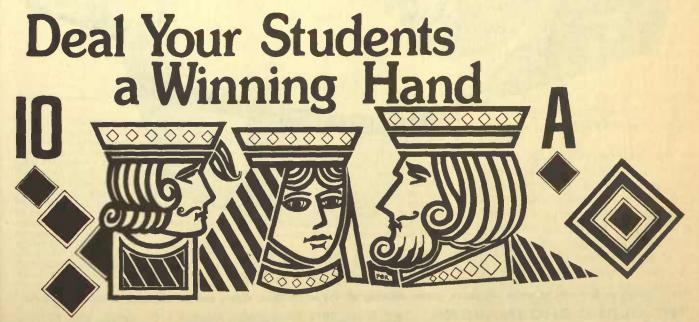
A multi-disciplinary approach to the study of the aged, this new anthology is organized to provide students with an understanding of the relationship between theory, research, and practice. The contributors emphasize sociological, developmental, and emotional factors in the on-going process of aging. Specific articles explore assessment of the elderly, nutrition and aging, management of grief and suicide.

Edited by VIRGINIA M. BRANTL, Ph.D.; and SISTER MARIE RAYMOND BROWN, R.S.M., M.N.Ed. July, 1973. Approx. 120 pages, 6" x 9". About \$3.95.

INSTRUCTORS NOTE: To receive a complimentary copy for firsthand evaluation, write to the Textbook Department, mentioning your position, course, and enrollment.

TIMES MIRROR

THE C. V. MOSBY COMPANY, LTO 86 NORTHLINE ROAD TORONTO, ONTARIO M48 3E5



# GRADUATE WITH HONORS



For a complimentary pair of white shoelaces, folder showing all the smart Clinic styles, and list of stores selling them, write:

THE CLINIC SHOEMAKERS • Dept. CN-6, 7912 Bonhomme Avenue • St. Louis, Mo. 63105

THE CANADIAN NURSE

JUNE 1973

## The Canadian Nurse



A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 69, Number 6

lune 1973

- 33 All in the Day's Work ...... L-E. Lockeberg

The views expressed in the editorial and various articles are those of the authors and do not necessarily represent the policies or views of the Canadian Nurses' Association.

5	News	43	Names
18	New Products	45	AV Aids
41	Dates	46	Books
42	In a Capsule	48	Accession List

Executive Director: Helen K. Mussallem • Editor: Virginia A. Lindabury • Assistant Editors: Liv-Ellen Lockeberg, Dorothy S. Starr • Editorial Assistant: Carol A. Dworkin • Production Assistant: Elizabeth A. Stanton • Circulation Manager: Beryl Darling • Advertising Manager: Georgina Clarke • Subscription Rates: Canada: one year, \$6.00; two years, \$11.00. Foreign: one year, \$6.50; two years, \$12.00. Single copies: .75 cents each. Make cheques or money orders payable to the Canadian Nurses' Association. • Change of Address: Six weeks' notice; the old address as well as the new are necessary, together with registration number in a provincial nurses' association, where applicable. Not responsible for journals lost in mail due to errors in address.

Manuscript Information: "The Canadian Nurse" welcomes unsolicited articles. All manuscripts should be typed, double-spaced, on one side of unruled paper leaving wide margins. Manuscripts are accepted for review for exclusive publication. The editor reserves the right to make the usual editorial changes. Photographs (glossy prints) and graphs and diagrams (drawn in india ink on white paper) are welcomed with such articles. The editor is not committed to publish all articles sent, nor to indicate definite dates of publication.

Postage paid in cash at third class rate MONTREAL, P.O. Permit No. 10,001. 50 The Driveway, Ottawa, Ontario. K2P 1E2

Canadian Nurses' Association 1973.

As we have received a fair number of death notices lately, I decided to repeat part of an editorial that I wrote several years ago.

The obituary column last appeared in *The Canadian Nurse* in June 1966. Even so, many nurses who wish to honor the memory of a friend, a relative, or a colleague continue to send death notices to us for publication. We realize these readers are disappointed by our present policy, which limits the publication of obituaries to those nurses who are known nationally and internationally.

The decision to discontinue the obituary column was based on two reasons. First, we believed that the appearance of a person's obituary in this magazine was seldom "news" to those who knew her or him. By the time the notice was published, acquaintances of the deceased had read about the death in the local newspaper, in the provincial nurses' association bulletin, or in the alumni gazette; close friends had been informed earlier by word of mouth or by letter.

Second, notices of death that were submitted by persons unknown to the editorial staff had to be verified before being published. This rule was adhered to rigidly, especially after one of our "listings" turned out to be very much alive—and very angry.

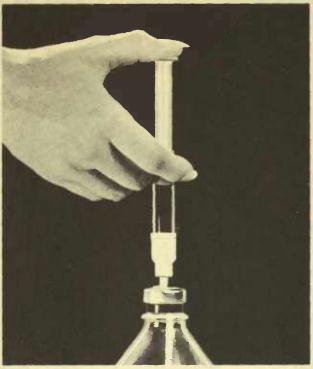
To prevent such embarrassments
— and to foil would-be pranksters
— a member of the editorial staff
would write to the registrar of the
nurses' association in the province
where the deceased had lived,
asking that the report of the death
be confirmed. In many instances
the registrar was unable to confirm
the report, and the obituary was not
printed.

Although death notices are no longer published in the journal, they are required by the journal's circulation department. When you notify the circulation department of a member's death, we ask that you enclose the registration number and the last known address of the deceased. The listing is then cancelled — a procedure that takes at least six weeks to go into effect.

- V.A.L

# Here is a new, fast and sterile way to prepare Xylocaine infusions

for life threatening arrhythmias



# **Xylocaine®**

(Lidocaine Hydrochloride Injection, Astra Std.)

ne Gra

- The special 5 ml transfer syringe contains 200 mg/ml Xylocaine and can be added to infusion set-ups without removing solution from infusion flask or bag
- Cuts preparation time in half
- Easy and convenient to use
- Adds another link to the sterility chain
- Disposable
- Clearly labeled for positive safeguard against error

ASTRA Pharmaceutical Division, Mississauga, Ontario



### news

Special Committee On Research **Continued By CNA Directors** 

Ottawa — At the board meeting on April 11, 1973, directors of the Canadian Nurses' Association voted to extend the special committee on research for a further two years. The role and activities of the special committee are to be reviewed and assessed by the directors in 1975.

The directors revised the terms of reference for the research committee. They are now: To assist the association in the implementation of its research policy, to make recommendations to the board regarding the association's role with respect to nursing research, to serve in a consultative and advisory capacity to the board of directors, and to carry out such other activities as may be assigned to it by the board.

CNA's policy on nursing research was printed in News, August 1972,

page 13.

Directors empowered the officers of CNA to name 10 members of the committee for 1973-75 from the nominations made by provincial associations. Each provincial association is invited to nominate nurses skilled in conducting research, implementing or diffusing research findings. The officers will choose the committee members to provide a mix of skills. In addition to these 10 members, the CNA executive director, the principal nursing officer and a nurse research consultant from Health and Welfare Canada, are to be members of the committee.

After discussion, the CNA directors agreed the research committee's terms of reference do not include regional representation. That is, members of the committee do not represent their provincial association; they are members of

a national committee.

Dr. Shirley Stinson, chairman of the research committee for 1971-73, told the board that a committee on research is a useful mechanism at this time, better than a task force, since there are many facets to research.

Directors accepted a recommendation that they examine various research activity ideas cited in the report of the committee and initiate activity in those areas considered to have priority.

Members of the research committee for the past two years, in addition to Dr. Stinson, Edmonton, were: Dr.

Shirley Alcoe, Fredericton, N.B.; Dr. Moyra Allen, Montreal; Dr. Margaret Cahoon and Dr. Josephine Flaherty, Toronto; Dr. Helen Glass, Winnipeg; Dr. Floris King, Halifax; Huguette Labelle, Ottawa; Sr. Marie Simone Roach, Antigonish, N.S.; and Dr. Lucy Willis, Saskatoon, Saskatchewan.

### **CNA Membership Reverses Decision** On Eligibility For CNATS Board

Ottawa — Voting delegates at the 1973 annual meeting of the Canadian Nurses' Association, held on April 12, 1973, reversed an earlier decision of the CNA directors that members of the test service board and committees must be currently licensed/registered, but need not be members of a provincial association. (News, March 1973, page 11.)

The resolution carried at the annual meeting is: "Whereas the recent decision by the board of directors regarding eligibility for the test service board and test service committees appears to allow decisions in the test service to be made by nurses who do not belong to their professional association; and whereas the CNA is the parent body whose primary aim is to foster the development and unity of professional nursing; be it resolved that nurse members of the test service board be required to be members of CNA.

The motion originally called for nurse members of the test service board to be members of their provincial nurses' association. It was pointed out that CNA can more appropriately require members of a CNA special committee (the test service board) to be its own members than to be members of another organization. Membership in a provincial nursing association is the prerequisite to CNA membership.

A second resolution passed by the voting delegates at the 1973 annual meeting asked CNA to urge the government of Canada to take steps to ensure that federal regulations for the adequate equipping and safe operation of aircraft transporting patients and health workers are enforced, and to inform nurses of their rights and responsibilities to insist that their patients are transported only by properly certificated air carriers.

The resolution's proposer, Dr. Josephine Flaherty, said federal regula-

tions are complete in themselves but these regulations are not being adhered to, especially with respect to small aircraft.

Voting delegates also accepted a resolution asking CNA's directors to consider a reduction in fee for CNA members taking the extension course in nursing unit administration. The course is cosponsored by CNA and the Canadian Hospital Association.

Accreditation was the topic of a workshop held during the afternoon session of the annual meeting. Arising from the workshop was a resolution asking that nurses be included as full partners in the work of the Canadian Council of Hospital Accreditation (CCHA) survey teams. CNA is now a full member of the CCHA. (News, October 1972, page 8.) The resolution, accepted by voting delegates, specified full partnership for nurses as participants in the preparatory seminars before survey visits, contributors to the selection of survey team members, and as participants in the survey process and on-site

In addition to workshops on accreditation and legislation, a workshop was held on specialization in nursing.

In her presidential address, Marguerite Schumacher said: "In my opinion, CNA is frequently one step behind. In the next year, can we be ahead in identifying and presenting issues?"

**ANPQ Success In Defining Nursing Explained At CNA Annual Meeting** 

Ottawa --- At a workshop on legislation, held during the annual meeting of Canadian Nurses' Association April 12, nurses from various provinces wanted to know the same thing: how did the Association of Nurses of the Province of Quebec get agreement on a definition of nursing and how did it mobilize its membership to get its voice heard?

The nurses present heard the background story of Bill 250 (the Professional Code) and Bill 273 (the Nurses' Act) from Nicole Du Mouchel, executive director and secretary registrar of ANPQ. She explained that when the association was given 30 days in December 1971 to reply to the government's proposed Nurses' Act, "we had 10 days to define nursing. Either 40,000 people agreed to nursing in Quebec, legally, or we would die." This was the first time the Quebec legislature attempted to define the act of nursing.

In January 1972, an ad hoc committee, set up to define the act of nursing, came up with a definition. A working paper was then prepared and sent to some 200 nurses in the province; the result was a new definition, which distinguished between dependent and independent functions.

In June 1972, ANPQ sent 10,000 questionnaires on the act of nursing to nurses across the province, and there was a 73 percent return, Ms. Du Mouchel pointed out. The purpose of the questionnaire was to show the activities that are on the border between the practice of medicine and the practice

of nursing.

"We are now doing a complete analysis of these questionnaires," Ms. Du Mouchel said. From this analysis, she explained, "we were able to prove that in Mr. Castonguay's riding, nurses were giving injections — a medical act." She also said ANPQ must prove the definition of nursing according to scientific research "so no one can challenge it."

With 40,000 ANPQ members and only 108 members of the legislature, "we get what we want in the long run," said Ms. Du Mouchel. But she noted, "we use a very constructive approach." Explaining that "the educational lobbying has been the secret," she said ANPQ representatives have attended all sessions of the National Assembly that have dealt with legislation affecting nursing.

In her explanation of strategy, Ms. Du Mouchel pointed to the role of ANPQ's public relations officer, who is a nurse. "She opens the door, gets us appointments [with members of the legislature], and makes the major

points."

Throughout 1972, Ms. Du Mouchel, ANPQ president Rachel Bureau, the public relations officer, and other ANPQ representatives attended meetings of the parliamentary committee on the professional code and met with various members of the National Assembly. The importance of this was made clear by Ms. Du Mouchel, who explained that the legislators didn't know anything about nursing before the legislation was introduced. "Now they refer a lot to research the nurses have done,"

When the first reprint of Bill 273

### Reception In Honor Of New Jeanne Mance Stamp



A reception was held at the Hôtel-Dieu de Montréal Hospital on April 18, the day the stamp honoring Jeanne Mance was issued. A special folio on the new stamp, given to the Canadian Nurses' Association at the reception, is displayed in the archives of CNA House. At the reception were *left to right* Claire Bigué, editor of *L'infirmière canadienne*, representing CNA; Raymond Bellemare, designer of the stamp; and Esther Foy, representing the Association of Nurses of the Province of Quebec. Ms. Bigué is shown holding the special folio.

was presented in the National Assembly in first reading in December 1972, "it was almost the definition [of the act of nursing] we had proposed," Ms. Du Mouchel told the workshop. One of the tips she had for the nurses present concerned sending briefs to legislators. The secret is not to send a summary at the same time the brief is sent, she said, because the summary won't be read. A summary should be sent a few days later, she advised.

Conferences and meetings were held

throughout 1972 to help keep all nurses up-to-date on the legislation, to give them information on ANPQ's position, and to request their support. Written news was also sent to the nurses regularly. An ANPQ special general meeting in August 1972, which allowed some 2,000 members in eight cities to participate through a telephone hookup, brought unanimous support for the association's position on the definition of nursing, Ms. Du Mouchel said.

(Continued on page 10)

# The Gentle Ones

Minimize trauma to sensitive mucosa with the Gentle Ones — Davol's unexcelled quality 22", 20", 18" and 16" rubber suction catheters. Made of soft, gentle, X-ray opaque red latex, with specially formed tips.

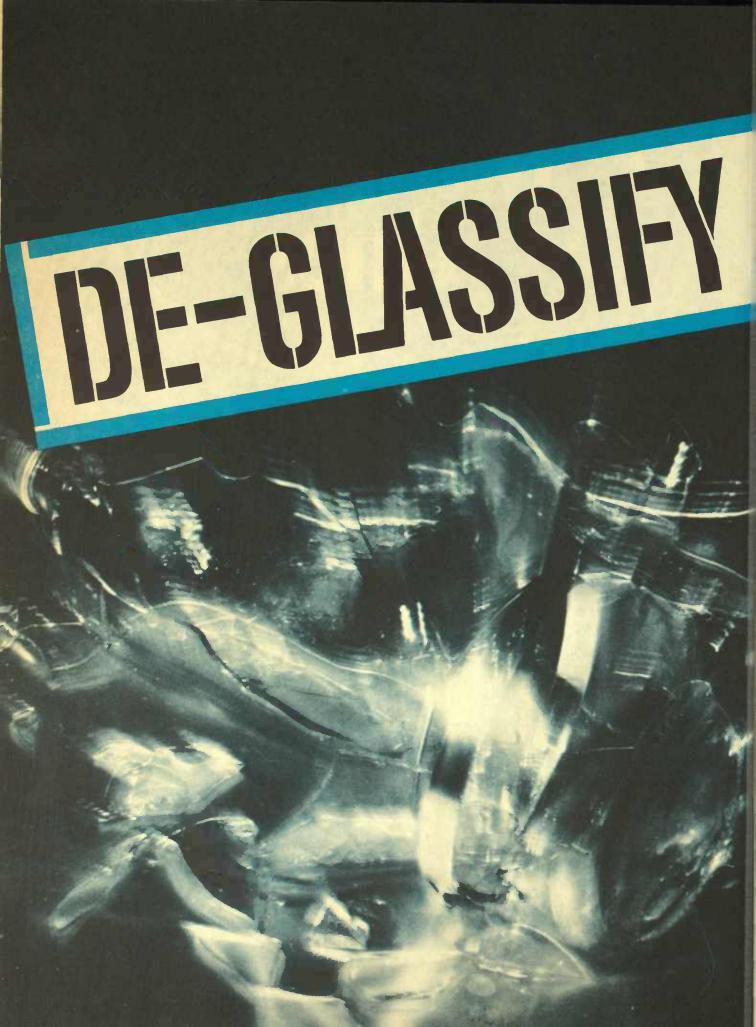
But don't be fooled. The Gentle Ones are also strong. With properly proportioned eyes for aspirating thick, tenacious exudate. Sturdy, full-flared funnels to allow quick, positive connections to suction tubing. Control valves for manual control of suction, raised to prevent finger contamination by the exudate. And strong, pliable, uniformly smooth surfaces to make insertion easy.

Davol single-use latex catheters are now available in a greater choice of lengths and French sizes; there's a new 22" catheter with control vent to complete the line.

And they come sterile in individual see-through, peel-back packages.

DAVOL

So make a point to ask your Davol Dealer Salesman about the Gentle Ories, Davol Inc., Providence, Rhode Island 02901. A Subsidiary of International Paper Company.



# TAKE THE BOTTLE PROBLEMS OUT OF YOUR IRRIGATION PROCEDURES WITH FLEXIBLE UROMATIC® PLASTIC CONTAINERS

DROP ONE. No breakage. No spillage. No dangerous mess... No cleanup.

FEEL HOW MUCH LIGHTER a plastic container with 3000 ml of solution is . . . 30% lighter than glass.

HANDLE THE SOFT FLEXIBLE CONTAINER. Note how easy it is to get a good grip on it—even when wet.

FORGET THE GLASS BOTTLE JUGGLING ACT. Changeover during surgery is accomplished easily and safely with the UROMATIC containers still hung in the in-use position.

NOTICE THAT THE SOLUTION HAS FEWER BUBBLES. This is a closed system. Air venting is not required so the urologist has greater assurance of a clear, bubble-free view through the scope during the procedure.

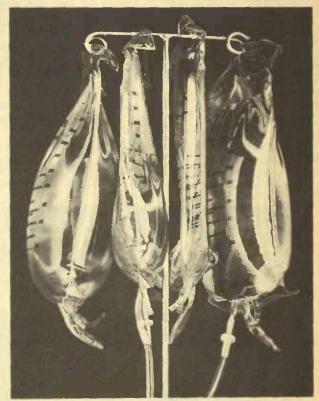
DISPOSE OF THE EMPTIES. Soft, flat, practically weightless, ready to drop into any nearby receptacle. Floors are free from the hazards and nuisance of empty bottles.

You probably have enough reasons right now to switch from bottles to the Baxter UROMATIC plastic containers. But here are just a few more. There's the time you don't spend cleaning up a mess of empty bottles or shattered glass. The fingers you don't cut on metal caps and glass fragments. There's the storage space you save with UROMATIC containers. They require approximately 30% less shelf space than glass. And then there's the extra dividend of better dispositions that come with DE-GLASSIFICATION.

So why stay stuck in the glass age, fighting the battle of the bottle? Why not talk to your Baxter representative today and discover how much easier life can be?



BAXTER LABORATORIES OF CANADA DIVISION OF TRAVENOL LABORATORIES, INC. 6405 Northam Drive, Malton, Ontario



### news

(Continued from page 6)

In September 1972, when Ms. Du Mouchel and Ms. Bureau presented a brief on Bills 250 and 273 to the parliamentary committee on the professional code, more than 350 nurses were there to applaud (News, November 1972, page 14).

The importance of press coverage was also stressed by Ms. Du Mouchel. "We're quoted regularly. We're getting a lot of press coverage — nursing is being talked about. Silence is dangerous

at this point.'

In 1973, ANPQ representatives—including the executive director, president, first vice-president (English) and consultants in continuing education and legislation—have taken part in a number of English and Frenchlanguage radio and television programs. They have also been interviewed by newspaper reporters. In this way, the public has been kept informed on ANPQ's positions respecting the new legislation.

ANPQ's executive director also spoke

of the importance of a strong professional voice at the national level. "If there is strong national body... taking stands on health and making them known by doing a lot of publicity and speaking loudly for nursing, we will have a much easier task in our own provinces."

Nurses at the workshop agreed that the Canadian Nurses' Association should use Quebec as a model for what other provinces can do. It was suggested that CNA ask the other provinces to react to ANPQ's definition of nursing

practice.

Ms. Du Mouchel said it is CNA's job to publicize what is being done in the nursing profession in Canada. "The publicity done in Quebec helped the legislators know what is being done," she noted.

Summing up her advice, she said: "Never take 'no' for an answer. If at first you don't succeed, try again and, even if you get a negative answer, something positive will come out."

**Preparing Nurses For Community Is Topic Of Fall Conference** 

Ottawa — A national conference on the preparation of nurses for community service is being planned by the Canadian Nurses' Association to take place in Ottawa November 13 to 16, 1973. CNA has applied to the federal government for a national health grant to finance the conference.

This will be a closed meeting, with participation by invitation only. Between 150 and 200 persons are expected to attend, including representatives of each provincial nurses' association, provincial health and provincial education departments, national health associations, and nursing students.

On the first day of the conference, which will begin at 1:30 P.M., there will be a keynote address, followed by a consumers panel. A variety of people representing consumers will include, for example, a mother, a recently hospitalized person, and a senior citizen.

The second day will focus on the nursing care needs in health agencies. Representatives of hospital, long-term care, public health, and primary care nursing will take part in a panel discussion.

Education day, which will focus on innovative programs, will follow on the third day of the conference. A panel on "preparing nurses for health care needs" will include nursing educators from a primary care nursing program, a CEGEP program, a university program, and continuing education.

The emphasis on the second and third days will be innovative thinking in the use and preparation of nursing

personnel.

On the final morning, there will be reports from the workshops held on the previous afternoon, an open forum, and a summary.

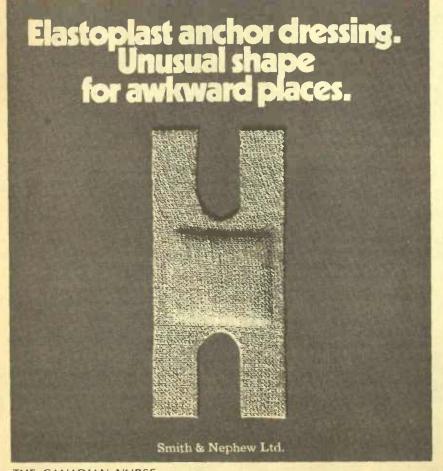
Names of the 12 panel members and each day's chairman, coordinator, and summarizer will be published in the near future. The conference fee has not yet been decided.

1,755 Nurses Discuss Legislation At ANPQ Meeting Via Phone Relays

Montreal — On April 18, the Association of Nurses of the Province of Quebec (ANPQ) held an information meeting in Montreal and eight other Quebec communities, using telephone relays to enable 1,755 nurses to hear presentations on action taken by ANPQ and to ask questions about current health legislation in Quebec.

Besides more than 800 nurses meeting in Montreal, nurses gathered in Sherbrooke, Hull, Quebec City, Rouyn, Three Rivers, Chicoutimi, Mont-Joli, and Sept-lles. The closed circuit voice network of telephones and amplifiers made it possible for a nurse in Mont-Joli, for example, to ask a question; the nurse in Montreal to answer it; and nurses in all eight centers to

(Continued on page 12)





A capsule account of some issues being examined by the Canadian Nurses' Association's board of directors at their meetings on April 11 and 12, 1973.

- Overuse of drugs: The resolution from the 1972 annual meeting on overuse of drugs and misuse of prescription drugs (Report, September 1972, page 31), was discussed by the joint committee of Canadian Hospital Association (CHA), Canadian Medical Association (CMA), and CNA in February 1973. All members of the joint committee supported the resolution. Directors of all three associations have been asked by Health and Welfare Canada to support its health protection branch's campaign to reduce advertising of pharmaceuticals. CNA directors agreed to support the health protection branch in this.
- Proliferation of health workers: The joint CHA/CMA/ CNA committee at its February 1973 meeting supported a CNA proposal to promote a full-scale multidisciplinary study of the proliferation of health workers. The executive director, Dr. Mussallem, reported to the board that CNA staff is working with a doctoral student who plans to conduct research on this subject for his dissertation.
- Specialization in nursing: A position paper on this subject, prepared by staff, is to be revised to include comments from the workshop at the annual meeting; it will be presented to the October board meeting.
- CNA liaison with other nursing groups: Directors named a committee of three to develop a discussion paper on CNA liaison with such groups as: national associations of specialty nurses; nonregistered nurses, the national association of nursing assistants, psychiatric nurses; and provincial associations of student nurses.

- Three major roles of a professional organization: Since many changes are going on, the directors decided not to issue a statement on the major roles of a professional organization. A working paper on this topic is available from CNA House. (News, March 1973, page 17.)
- Accreditation of programs in nursing education: A meeting has been held of representatives of nursing and general education. Considerable doubt was expressed as to whether accreditation is the sole answer to improvement of education programs for nurses. The committee recommended that the climate for accreditation should be tested by a questionnaire addressed to provincial nurses' associations. The directors agreed the sampling should be tried.
- Participation in Canadian Council on Hospital Accreditation: To support Isobel MacLeod, CNA's representative on the CCHA, the directors agreed to invite Ms. MacLeod to attend the October board meeting and to send information on current CCHA issues to board members before the meeting.
- CNA position on smoking: A position statement on smoking, accepted by the directors, is printed on page 15.
- CNA position statement on the primary care nurse: Directors accepted a CNA position on the primary care nurse, printed on page 13, which goes beyond the joint CNA/CMA statement (May 1972, page 23.)

### news

• Annual meeting resolutions: At the board meeting following the 1973 annual meeting, directors took action on the resolutions accepted. (News, June 1973, page 11). Staff are to develop a brief and present it to the government, concerning aircraft transporting patients and health workers. The resolution on fees for the nursing unit administration (NUA) course will be forwarded to the CNA/CHA committee on the course.

A letter will be sent to the CNA test service board requesting that henceforth suggestions of names of potential test service board members be submitted to the CNA board for appointment; the CNA board will be responsible for ascertaining that they are CNA members. A copy of the

resolution on full participation in the survey work of the Canadian Council on Hospital Accreditation will be sent to the president and members of CCHA.

- Nursing requirements study: A study of methods of forecasting the numbers of nurses and nursing assistants needed over the next five years has been completed and submitted to Health and Welfare Canada who requested it. CNA has applied for a federal grant to develop a microsimulation of the forecasting model presented in the CNA study.
- CNA test service: Directors established a three-member committee, made up of individuals not directly involved with the CNA test service, to study the test service relation to CNA; the committee is to report with a plan of action within one year. Directors gave the director of administration, test service, the authority and responsibility to invest surplus funds in the test service bank account in accordance with the general investment policies of CNA.

(Continued from page 10)

hear both question and answer.

At a special meeting in August 1972, voting delegates supported the ANPQ's stand on changes needed in regulations to implement Quebec's Bill 65, the act transferring all health services to public control. (News, October 1972,

page 8.)

On April 18, ANPQ members heard that most of the changes supported by membership in August have been accepted by the government. Most notable is the requirement that each hospital center must have a department of nursing service, headed by a nurse director who is responsible to the general manager of the hospital. Prior to the change, the nursing department was not a requirement and, if it existed, the head of the department was responsible to the chief of hospital services, under the general manager.

The definition of the act of nursing, as published in the reprint of the first reading of Bill 273 (the Nurses' Act) is: "Every act the object of which is to identify the health needs of persons, contribute to methods of diagnosis, provide and control the nursing care required for the promotion of health, prevention of illness, treatment and rehabilitation, and to provide care according to a medical prescription constitutes the profession of nursing."

It was pointed out, at the April 18 meeting, that the functions of education and planning are not included in the revised definition; the ANPQ insist on

their inclusion.

Rachel Bureau, president of ANPQ, told members at the information session: "We were disappointed not to find, in the reprint of Bill 273, first reading, any clause assuring the Corporation [ANPQ] of the right to

oversee the basic nursing course. This right is in our present Act. If the legislature does not accede to our request, we will not be able to answer to the public for the quality of the training of our members. In the interests of the Quebec people, we will either have to refuse admission[to registration examinations] to these students or else subject them to courses and/or additional clinical experience; in both instances, these students will be penalized.

"We have made several requests in relation to the management of the Corporation. These requests have not been included in the reprint of Bill 273. However, in his speech introducing the Bill in second reading, Mr. Castonguay, minister of social affairs, stated that several amendments would be made to the Bill enabling the ANPQ to function, taking into account its 40,000 members spread out in all

regions of the province."

The requests are that a system of voting delegates be used to make decisions at the annual meeting (the Bill provides for universal suffrage); that the expenses of voting delegates be met by the association (the Bill makes no such provision to enable association members to attend annual meetings held a distance from their homes); and that the association collect members' dues and remit a per capita fee to the district (the Bill provides for the districts to fix their own fees and send a fixed amount to the provincial association).

Ms. Bureau said serious attempts have been made to have management nurses included in the section of Chapter 48 (the Act concerning health services and social services) dealing with arbitration procedures provided for

encroachments on the rights of doctors and dentists. Members of the nursing profession at management level have no job security. ANPQ has made numerous representations to the department of social affairs, to no avail. "We will keep on with our petitions, as these members must be protected," Ms. Bureau said.

Priorities of the ANPQ for the remainder of 1973 were discussed at the information day. They include illustrating and substantiating the definition of the act of nursing; research on acts delegated to nursing and new nursing roles: work inherent in Bills 250 (code of the professions) and 273 (the Nurses' Act), such as developing methods of inspection of nursing practice, preparing bylaws to incorporate responsibilities given ANPQ by the two bills, and writing a code of ethics, required by Bill 250.

The ANPQ has also given priority to basic and continuing education projects, including evaluation of: nursing education in the CEGEPs, clinical resources, and college programs with a view to accreditation; decentralizing the locations for examinations; justifying exams as the evaluation tool for admission to the profession; preparing model classes; and carrying out pilot

projects in two colleges.

A continuing priority of the ANPQ is information on members, other disciplines, government, and the public.

At the close of the information session, Sheila O'Neill, first vice-president (English) of ANPQ said: "The government in power has become aware of changing health needs. Nurses have become aware of their potential. If we can put it all together, we have a precedent-setting opportunity."

12 THE CANADIAN NURSE

### CNA Policy Statements on The Primary Care Nurse

CNA believes that accessibility to and effectiveness of Canadian health services can be increased through expansion of the roles of nurses. For example, nurses should have an enlarged role in primary health care.

Three areas in which immediate action could be taken to utilize nurses more effectively are:

1. primary care for ambulatory patients

2. continuing care for convalescent and long-term patients

3. preventive care toward conservation of health.

CNA believes that preparation for primary care nursing should be part of basic nursing education.

CNA believes that until preparation for primary care is included in basic nursing education, both long- and short-term courses shall be available to prepare nurses to function in primary care settings. Where possible, these courses shall be developed and implemented in university health science centers. The administrative authority shall rest with the faculties of nursing.

CNA believes that remuneration for the primary care nurse should be on a salary basis. This salary shall be adequate, competitive, and include recognition of responsibility, experience, educational qualification, seniority, as well as income security benefits, such as sick leave and pensions.

### Registered Nurses' Association Formed In Northwest Territories

Yellowknife, N.W.T.—A registered nurses' association now exists in the Northwest Territories. In March 1973, nurses in the Territories received the final draft of the constitution and bylaws for the voluntary association, Northwest Territories Registered Nurses' Association (NWTRNA).

In the summer of 1972, nurses from the Yellowknife Nurses' Association, in consultation with the Fort Smith Nurses' Association, produced a constitution and bylaws "to allow nurses the privilege of speaking as a body." The nurses wanted to be able to speak as an official group at the January 1973 Territorial Council session, when legislation for registered nurses and certified nursing assistants came before it. A Nursing Ordinance was passed.

There will be mandatory licensing for registered nurses in the Territories, with an initial operation fee of \$10. Being licensed under the N.W.T Nurses' Ordinance will eliminate the need for nurses to belong to a provincial association while they are employed in the Northwest Territories (News, August 1972, page 8).

Doctors, too, are presently licensed in the Northwest Territories through the territorial government.

A steering committee, composed of three members from Yellowknife District and Fort Smith District, will

**JUNE 1973** 

guide the NWTRNA until its first general meeting, expected to be held in March or April 1974, in Yellowknife. At this meeting, members will be able to elect a president, president-elect, and chairmen of education and nursing administration committees.

Plans for the new association include clude a workshop in conjunction with the annual meeting, and a newsletter. This year there will be no fee to join the association. Almost 60 members are expected to belong in the beginning.

Colloquium On Nursing Research Held At McGill University

Montreal — Forty-five nurse researchers attended a national colloquium sponsored by the schools of nursing of McGill University, the University of Montreal, and Laval University on March 28 to 30, 1973. Participants came from all provinces except Newfoundland and P.E.I.

The colloquium was held to allow a group of nurses actually working in research to discuss common problems in the projects in which they are engaged. Presentations were recorded on videotape for use by advanced students of nursing and other health professionals across Canada.

Money for the colloquium was obtained by a national health grant,

(Continued on page 15)

# The least you can do for hospitalized diabetics

It's not that you should do more. It's just that KETO-DIASTIX\* Reagent Strips require the least amount of effort in testing for glucose and ketones in urine. Simply dip into urine and get a semiquantitative reading for glucose and ketones in 30 seconds. What could be easier and less troublesome for you and the patient? Useful all around the hospital. On wards, at the bedside, in patient teaching centers, and in the O.P.D. Also, a good test to recommend for the patient to use at home after discharge. Obtain full details on KETO-DIASTIX by calling your Ames Systems Specialist or by writing to the address below. It's the least work you can do in diabetic urine testing.

### **Keto-Diastix**

**Ames Company** 



Division Miles Laboratories, Ltd 77 Belfield Road, Rexdale, Ontario

"Chamical and biological Information systems serving Medicine and Industry"



Vew Duotone Design now available MRS. R. F. JOHNSON SUPERVISOR CHARLENE HAYNES MRS. HOLBRUUN ANN COHN, L.P.N.

# Name Pins 'n Things...from Reeves

### IT'S EASY TO ORDER REEVES NAME PINS FOR YOURSELF OR FRIENDS!

Choose style you want, shown left. Print name (and 2nd line if desired) on dotted lines below. Check other info in boxes on chart, clip this section and attach to coupon

bottom left. Attach extra sheet for additional pins. NOTE SAYINGS ON 2 IDENTICAL PINS . . . mare convenient, spare in case of loss

GACKGROUND COLDR (Plastic) PRICES" STYLE NO. DESCRIPTION Engraved 1 Line | Engraved 2 Lines ALL METAL . . . rich, trim and tailored. Lightweight, smooth edges, rounded corners. Black
Dk. Blu
White Does Gold ☐ 1 Pin 1.98 ☐ 1 Pin 169 2 Pins 3.25 2 Pins 3.85 Black Ok. Blu PLASTIC LAMINATE Does ☐ 1 Pin 1.45 ru surface to or. Beveled 559 Med. Green Med. Blue 2 Pins 1.65 2 Pins 2.30 apply apply METAL FRAMED ... Class White 100 OLDED PLASTIC...Simple,sm conomical. Will never discolor. mooth rounded corners and edg White ☐ Black ☐ Dk. Blue ☐ 1 Pin .95 ☐ 1 Pin ☐ 2 Pins 1.65 ☐ 2 Pins 510

\*Please add 25¢ per order for 3 pins or less.

QUANTITY DISCOUNTS: 10-24 pins, deduct 10% 25-99 pins, 15%; 100 or more pins, 20%.



SCOPE SACK neatly carries and protects Nursescope or any scape. Oouble-thick frosted flexible plastic, white vinyl binding. 4½" x 9½". Your own initials help prevent loss. No. 223 Sack...1.00 ea. 6 or more 75¢ ea. Your initials gold-stamped, add 50¢ per sack.

### NURSES PERSONALIZED ANEROID SPHYG.

ANCROID SPITTU.

A superb instrument especially designed for nurses! Imported from precision craftsmen in W. Germany. Easy-to-attach Veltoro cutf. lightweight, compact, fits into soft sim. teather zippered case 2½° x4′ x 7″. Dia Calibrated to 320 mm., 10-year accuracy guaranteed to 23 mm. Serviced by Reeves if ever required. Your initials engraved on manometer and gold stamped on case FREE, for permanent identification and distinction. A wise investment for a lifetime of dependable service! No. 106 Sphyg. . . . 32.95 ea.



MEDI-CARD SET Handiest reference ever! 6 smeoth plastic cards (3½" x 5½") crammed with information, including Equivalencles of Apothecary to Metric to Household Meas, Temp. \*C to \*F, Prescrip. Abbr., Virnlayis, Body Chem., Blood Chem., Liver Tests, Bone Merrow, Disease Incub. Periods, Adult Wgts, Child's Dosages, etc. All in white vinyl holder with gold stamped caduceus. No. 289 Card Set . . . 1.50 ea. 6 or more 1.25 ea. 12 or more 1.10 ea. Your initials gold-stamped on holder, add 50¢ per set. KELLY FORCEPS So handy for every nurse! 5½" stainless steel, fully guaranteed. Ideal for clamping off tubing. Your own initials help prevent loss.

CAR No. 25-72 Forceps . . . 2.75 ea. 6 or more 2.50 ea. Your initials engraved, add 50¢ per forceps.



### CAP ACCESSORIES

CAP TOTE keeps your caps crisp and clean while stored or carried. Flexible clear plastic, white trim, zipper, carrying strap, hang loop. Stores flat. Also for wiglets, curlers, etc. 8½" dia., 6" high.

No. 333 Tote . . 2.65 ea., 6 or more . . 2.35 ea. Your initials gold-stamped, add 50¢ per Tote.



WHITE CAP CLIPS WHITE CAP CLIPS Holds caps firmly in place! Hard-to-find white bobbie pins, enamel on fine spring steel. Eight 2" and eight 3" clips included in plastic snap box. No. 529 Clips . . 3 boxes for 1.95, 6 for 3.25, 12 for 49¢ ea.

(NAJ)

### MOLDED CAP TACS

Replace cap band instantly. Tiny plastic tac, dainty caduceus. Choose Black, Blue, White or Crystal with Gold Caduceus; or all Black (plain). The neater way to fasten bands.





METAL CAP TACS Pair of dainty ivier AL CAF Tall of canning in the control of the

SEL-FIX CAP BAND Black velvet SELFIX CAP BANU Black vertex band material. Self-adhesive, presses on, pulls off; no sewing or pinning. Reusable several times. Each band 20" long, pre-cut to popular widths: ¼" (12 per plastic box) ¼" (6 per box) ½" (6 per box) ½" (6 per box). Specify width under ITEM column on coupon, No. 6343 8and. . . 1.75 per box



Zip

	110: 0343 Cand: 1.73 per cox 3 or more 1.30 ca.								
	TU REEVES	COMPANY, Bo	x C . At	tlebor	o, Mass	112703			
	OROER NO.	ITEM	COLOR	SIZE	QUANT.	PRICE			
Ė			-		- 1				
SI,									
U			-	-	-				
	Use extra sheet for additional items or orders.  INITIALS as desired:  Good idea for distinctive identification)								
ı	TO OROER NAME PINS, fill out all information in box top right, clip out and attach to this coupon.								
	l enclose \$(Mass. residents add 3% S. T,) Sorry, no COD's or billing terms available								

State

### Free Initials and Scope Sack with your own Littmann Nursescope



Famous Littmann nurses diaphragm stethoscope . . . a fine precision instrument, with high sensitivity for blood pressures, apical pulse rate. Only 2 ozs., fits in pocket, with gray vinyl anti-collapse tubing, non-chilling epoxy diaphragm. 28" over-all. Non-rotating angled ear tubes and chest piece beau-tifully styled in choice of 5 jewel-like colors: Goldtone, Silvertone, Blue, Green, Pink.\*

FREE INITIALS AND SACK! Your initials engraved FREE on chest piece; lend individ-ual distinction and help prevent loss. Also FREE SCOPE SACK included, worth \$1. as described above right. (Free sacks not personalized; add 50g if initials desired.) Ideal for group gifts! Note big sav-ings on quantity orders (left).

No. 216 Nursescope... ings on quantity orders (left).
13.80 ea. ppd.
6-11...12.80 ea. 12 or more...11.80 ea.
Group Discounts include free Initials and Sack! "IMPORTANT NEW FEATURE: New "Medallion" styling includes tubing in colors to match metal parts. If desired, please add \$1, ea. to all prices above, and add "M" to Order No. (No. 216M) on coupon. Duty free

SCISSORS Precision-made imported forged steel.
Professional quality. Guaranteed 2 years.



31/2" LISTER MINI-SCISSORS Finy, handy, slip into uniform pocket or purse. Choose jewelers Gold or gleaming Chrome plate finish on coupon. No. 3500 Mini-Scissors . . . 2.75 ea

41/2" or 51/2" LISTER SCISSORS As above, but larger for bigger jobs. Chrome finish only No. 4500  $(4\frac{1}{2}")$  or No. 5500  $(5\frac{1}{2}")$  Scissors . . . 2.75

51/2" OPERATING SCISSORS Stainless steel, with sharp/blunt points. Beautifully polished finish

No. 705 OR Scissors . . . 2.75 ea.

All scissors above: 1 doz, or more lany style) . . . . Your initials engraved, add 50c per scissors.



weight imported dual scope; highest sensitivity for apic, pulse rate. Chromed head tubes and chest piece with 14%" bell and 11%" diaphragm, grey anti-collapse tubing, 4 oz., 29" long. Extra ear plugs and diaphragm included. Two initials engraved free. (D) No. 413 Dual Steth . . . . . . . 17.95 ea.

### JEWELRY

NURSES CHARMS

Finest sculptured Fisher charms

Sterling or Gold Filled (specify under COLDR on coupon)

For bracelet or pendant chain. Add to your collection! No. 263 Caduceus; No. 164 Cap; No. 68 Grad. Hat; No. 8. Band. Scissors . 3.49 ea.



14K PIERCED EARRINGS Dainty, detailed 14K Gold styles, for on or off duty wear. Shown actual size. Beautifully gift boxed.

Tully girt boxed.

Birthstone Colors (specify on coupon): JAN
Garnet, FEB Amethyst, MAR Aqua, APR Crystal, MAY Emerald, JUNE Alexandrite, JULY
Ruby, AUG Peridot, SEPT Sapphire, OCT
Rose Zircon, NOV Topaz, OEC Blue Zircon.

No. 13/297 Caduceus; No. 13/276 Cross; No. 1/010 Gen. Cultured Pearl; No. 6/247 Birthstone \$5.95 per pair.

PIN GUARD Sculptured caduceus, chained to your professional letters, each with pinback/safety catch. Or replace either with class pin for safety. Gold finish, gift boxed. Choose RN, LFN or LVN, No. 3420 Pin Guard . . . . 2.95 ea.



Outy free

ENAMELED PINS Beautifully sculptured status insignia, 2-color keyed, hard-fired enamel on gold plate. Dime-sized, pini-back. Specify RN, LPN, PN, LVN, NA, or RPh. on coupon. No. 205 Enam. Pin 1.95 ea., 12 er more 1.50 ea.



CDA

PA

No. 210-E (right), two compartments with flap, gold stamped caduceus . . . 6 for 1.50, 25 or more 20¢ ea. No. 791 (left) Deluxe Saver, 3 compt. change pocket & key chain . . . 6 for 2.96, 25 or more 35, ea.



Nurses' POCKET PAL KIT Handiest for busy nurses. Includes white Deluxe Pocket Saver, with 5" Bandage Shear (both shown opposite page). Tri-Color ball-point pen, plus handsome little pen light . . all silver finished. Change compartment, key chain.

No. 291 Pal Kit . . . . . . . 4.95 ea. 3 Initials engraved on shears, add \$0¢ per kit.

BZZZ MEMO-TIMER Time hot packs, heat lamps, park maters. Remember to check vital signs give medication, etc. Lightweight, compact (114" dia.), sets to buzz 5 to 60 min. Key ring. Swiss made. No. M-22 Timer . . . . . 4.95 ea. 3 or more 3.95 ea.; 6 or more 3.50 ea.



EXAMINING PENLIGHT CDMD White barrel with caduceus imprint, aluminum band and clip. S" long, U.S. made, batteries included (replacement batteries available any store). Your own light, gift boxed. No. 007 Penlight . . . 3.98 ea. Your Initials engraved, add SOr per light.



### w Kork-Lites Featherweight Style

extremely lightweight professional walker, h the new "bottom" look. Smart, infortable lace-up heel oxford over neper toe lest. Thick simulated cork e with 11/6" cork heel (very slip istant, and outlwears crepe). led in white washable soft we upper leather, tricotve upper leather, tricoted, with arch vents. ecting trends in ay's fashions. Fit tranteed or return marred) for size

### No. 638 Kerk-Lite Shoe . . . 16.95 pr. All-Weather NURSES' CAPE

Stey snug in cool weather, dry in the rain. Traditional Navy with Bright Red lining. Finest tailoring of 65% Dacron polyester, 35% combed cotton. Zepel treated. 100% Nylon Ouralyn lining. Snap fasteners, arm openings. Matching head scarf, SMALL (up to 34 bust), MEDIUM (35-38) or LARGE (39-42) ... specify size on coupon.

No. 658 Cape . . . 3 Gold Initials on collar, add 1.00 per cape.

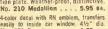
### GHTINGALE LAMP

:hange.

uthentic, unique favor, gift or engraved rd! Ceramic off-white candleholder with uine gold teaf trim. Recessed candle (candle not included). 7" long.



FIDOS Lamp. . 6,95 ea., 12 or more 4.95 ea. als and date engraved on gold plaque . . . 1.00 per famp.





elida Ri nisignia letti o bornaz-plated medalilan. Easy to attach to registration plate. We shether-prof. distinctive. No. 210 Medallion . . . 5.95 ea. 4-color decal with RN emblem, transfers easily to inside car window. 4½° dis. No. 621 Decal . . . . . . . . . . . 1.25 ea.

Endura NURSE'S WATCH Fine Swiss-made waterproof timepiece. Raised easy-to-read white numerals and hands on black dial, Juminous markings. Red sweep-second hand. Chrome finish, stainless back. Includes black velvet strap. Gift-boxed, with 1 year guarantee. 



CAR NURSES BAG A lifetime of service for visiting nurses! Finest black \( \frac{1}{2} \) thick genuine cowhide beautifully crafted with rugged stitched and rivet construction. Water repellant. Roomy interior, with snap-in washable liner and compartments to organize contents. Snap strap holds top open during use. Name card holder on end. The rugged carrying straps. 6" x 6" x 12". Your intrials gold embossed FREE on top. An outstanding value of superb quality.

No. 1544-1 Bag (with liner) . 37.95 ea. Extra liner No. 4415 . . . . 6.95 ea.

Fast-Action TOURNIQUET Strong, lightweight Velcro® strap applies, adjusts and releases instantly on any limb. Positive holding power, self-adjusting tension, eliminates "pinch". For blood samples, emergencies. Duty free

No. 2017-1 Tourniquet . . . . . 2.69 ea.

oint, with World-famous ballpoint, with sculptured caduceus emblem. Full name FREE engraved on barrel (include name with coupon). Refills avail. everywhere. Lifetime guarantee.

3502 Chrome 8.00 ea. No. 6602 12kt. G.F. 11.50 ea.

TRI-COLOR BALL PEN

Write in black, red and blue with one ball point pen of the thumb changes point (and color). Steno line point (excellent charts). Polished chrome finish. A handy accessory for every nurse! 



HORSESHOE KEY RING Clever, unusual design: one knob unscrews for inserting keys. Fine sterling silver throughout, with sterling sculptured caduceus charm. No bead chain to break! No. 96 Key Ring . . . . . . . . . . 4.95 ea.

### Pull-Out KEY-KEEPER

### news

(Continued from page 13)

including funds for the videotaping. The videotapes of the 11 presentations, and discussions of the problems identified in each, will be available in late summer 1973. Information on borrowing the videotapes may be obtained from Dr. Moyra Allen, McGill U. school of nursing.

A printed report of the colloquium will also be available in French and in

English.

Problems raised by participants included questions regarding the validity and accuracy of tools used for investigation, methods of classifying data, and problems of introducing research projects into the clinical situation without affecting the quality of health care given to patients.

Each presentation was followed by critiques by two discussants, in which the problems indicated by the researcher were examined and alternative approaches suggested, and then by general discussion.

In the concluding session, the participants made these points:

- the colloquium permitted nurses from all parts of Canada and from different working environments to meet colleagues who have achieved a high level of competence in nursing research;
- researchers are isolated, to some extent, and need counsel and dialogue with colleagues in the universities and health agencies;
- more and more nurses are working on interdisciplinary research teams in which researchers from different disciplines are experiencing difficulties in communicating and in coordinating efforts;
- nursing is becoming more concern-

### **CNA Policy Statement** on Smoking

Acknowledging the avoidable dangers of smoking to both smoker and nonsmoker, CNA believes that:

- 1. Associations of health professionals should play a leading role in initiating projects to create a nonsmoking society.
- 2. A concerted effort should be made by education- and health-related agencies, in conjunction with specialized government and voluntary agencies across Canada, to develop and implement a comprehensive program of research, education, treatment, and scientific evaluation, to prevent the commencement and continuation of smoking.
- 3. Students in health and teaching professions must receive sufficient indoctrination to make them enlightened and zealous educators. Treatment clinics should be made available to staff and students who smoke.
- 4. Health workers, educators, and community leaders have a responsibility to be exemplars to the public and to take every measure to prevent and reduce smoking, especially among young people.
- 5. Hospitals, health departments, and health-related services and facilities should, in the next 12 months, take action to protect the health of staff and patients by designating smoking areas and by prohibiting the sale of tobacco products within the agency.
- 6. All recommendations of the Standing Committee on Health, Welfare and Social Affairs on Tobacco and Cigarette Smoking should be implemented within the next 18 months. These recommendations include:

• counseling and treatment services, education, research, and scientific programs of evaluation aimed at prevention and reduction of smoking and at rendering smoking less hazardous to health and property;

• special screening, diagnostic, counseling, and treatment services for those at particular risk, that is, miners, asthamatics, those with existing or family history of hypertension, diabetes, cardiovascular, or gastric ail-

elimination of cigarette and tobacco sales promotion;

 assistance to tobacco growers and workers to diversify their activities from the tobacco industry.

### news

ed with action research, projects that study new methods of giving care.

Dr. Moyra Allen told The Canadian Nurse that the idea of a meeting for nurse researchers only was discussed after the first national conference on nursing research, held in February 1971. She said participants invited to the colloquium were selected according to the relevance of the problems they were researching.

Sask. Labor Relations Board Told To Rehear Nurses' Application

Regina, Sask. — The Saskatchewan Court of Appeal has ruled against a labor relations board decision that dismissed an application for certification by the Nipawin District Staff Nurses' Association (News, March 1973, page 11). The court has also instructed the board to rehear the case.

It was expected that the Nipawin application would come before the board during its next sitting, which was to begin May 1 in Saskatoon.

However, on April 25 it was learned that the union opposing the nurses' application has appealed the decision to the Supreme Court of Canada. The present sitting of the Supreme Court ends June 30 and the fall sitting begins October 1.

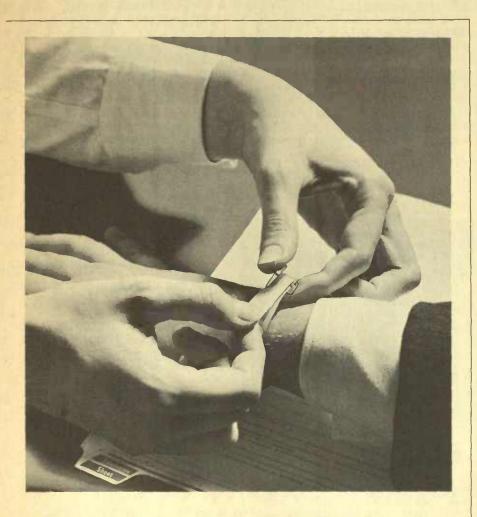
In 1972, the Nipawin association applied to be the bargaining agent for the nurses at Nipawin Union Hospital and Pineview Lodge Nursing Home in Nipawin. The Service Employees International Union opposed the nurses' application. The labor relations board rejected the association's bid because it said the Nipawin group was dominated by the Saskatchewan Registered Nurses' Association. The Nipawin association appealed the decision.

In a written judgment, Saskatchewan Chief Justice E.M. Culliton said the board acted outside its jurisdiction in finding the Nipawin association to be company-dominated. The chief justice said the board has the right to determine whether an applicant is a companydominated organization, but it must do so according to the definition of such an organization as outlined in the Trade Union Act. He noted "it was incumbent upon the board to say whether the Saskatchewan Registered Nurses' Association was an employer or an employer's agent" within the terms as defined by the act.

The chief justice said it was obvious from a review of the board's reasons that the board did not find the SRNA to be an employer or an employer's agent. "Nowhere in the reasons of the board is it suggested the SRNA in its association with the applicant, was acting for or on behalf of the employer named in the application, nor that it was acting for or on behalf of any other employer.'

Chief Justice Culliton also said the inquiry made by the board and the decision it reached were not founded on the provisions of the Trade Union Act, but upon the board's view of what constituted a company-dominated organization. "This the board was not empowered to do and thus acted in excess of its jurisdiction," he added.

According to the chief justice: "The board, if it did make a finding that the SRNA was an employer's agent, did so because it found that from time to time the council of that organization was made up of people who, in their private and personal employment, could be classified as management personnel and not as employees within the Trade Union Act." He said "This test is neither authorized by the act nor is it right in principle.'



### Just Press the Clip and It's Sealed

It takes but a moment to identify your patient, positively and permanently, with Ident-A-Band. Then just a glance is all you'll need to be sure that this is the right patient.

## Ident-A-Band



HOLLISTER LIMITED · 332 CONSUMERS ROAD, WILLOWDALE, ONTARIO

SRNA, SMA, SHA Conference Supports Joint Health Planning

Saskatoon, Sask. — At a two-day conference in March 1973, the Saskatchewan Medical Association, Saskatchewan Registered Nurses' Association, and Saskatchewan Hospital Association agreed to support a joint approach to planning and coordination of health services.

They agreed that a joint approach could be achieved only by forming a provincial health sciences council, which would initially have representation from the three associations.

This council is seen as an autonomous body that would attempt to establish its credibility with government, the public, and the member associations. It would start as a small group and gradually expand to include other health-oriented associations and societies as it becomes firmly established as a voluntary health planning agency.

Nurses, doctors, hospital trustees, government and consumer representatives, and members of the media attended the conference, which was patterned after a conference of the three national associations at Mont Gabriel. Quebec, in 1972. The national conference recommended that their provincial counterparts hold the same type of conference; Saskatchewan was the first to do so.

Six discussion groups identified the major general problem as the apparent lack of knowledge concerning the present health system. It was agreed that this was the result of an isolationist approach, in which each group of providers has developed its own areas of expertise and has functioned within them without paying enough attention to what other groups were doing.

After study of the recommendations of the Hastings Report on community health and social centers, there was agreement that Saskatchewan, with its diverse population densities, did not need a completely new system. It was suggested that pilot projects, based on the recommended system, be undertaken in selected rural and urban areas.

Noting a serious lack of adequate programs and facilities for the proper care of senior eitizens, the conference agreed that the health professions, the public, and government must place greater emphasis on this aspect of services. The conference expressed regret, too, at the low priority given to preventive health care.

Also pointed out was the lack of opportunity health professionals have to make their expertise available to governments before new policies and programs are set up for health care. The conference recognized that although governments have been anxious to get expert advice on health matters for **JUNE 1973** 

planning and operational purposes, they have worried that organized, vested interest groups may not provide them with the best advice.

Regina General Nurses' Alumnae Offers Graduates \$500 Scholarship

Regina, Sask. — This year the Regina General Hospital Nurses' Alumnae is again offering a \$500 scholarship for postbasic study at any university school

Applicants for this scholarship must be graduates of the Regina General

Hospital school of nursing, actively engaged in nursing, and a current member of the RGH nurses' alumnae. A letter of acceptance from the university of the applicant's choice must accompany the application. The deadline for applications is June 30, 1973.

Further information and application forms can be obtained from Roberta Walker, chairman of the scholarship committee, Suite 21, 1811 — 8th Avenue N., Regina, Saskatchewan. Membership in the alumnae is available for \$1 from Ms. J.E. Garvey, 2178 Argyle Street, Regina.

## Y P KINS (IN P P KI

is only part of the story



The pumps large volume of suction creates 0" to 27"+ of vacuum in seconds. Ideal for use in Operating Rooms, Delivery Rooms, Recovery Rooms and Emergency Rooms.

Suction can be precisely controlled. Conveniently located gauge, calibrated in both centimeters and inches, and regulator valve simplify operation.

■ Gomco Aerovent® Overflow Protection prevents damage to pump from flooding without the necessity of constant supervision.

■ Baked Lumitone® enamel finish with stainless steel top. All fittings are of chrome plated brass, all rubber parts, including large ball-bearing casters, are electrically conductive. Approved 3-conductor cord with explosion-proof plug is standard equipment.



### GOMCO SURGICAL

MANUFACTURING CORPORATION Buffalo, Naw York 14211 828 East Farry Street THE CANADIAN NURSE 17

# new products



Forearm Walker Attachments

### Forearm walker attachments

Lumex, Inc. has introduced forearm walker attachments to provide comfortable support and added safety for the patient with weak or arthritic hands and wrists. The attachments are made for easy installation on Lumex walker models 6000, 6010, 6030, and 6080, and on other makes of walkers of similar dimensions.

The attachments, which extend six inches above the walker handgrip level, feature padded and contoured forearm rests. Adjustable Velcro straps provide nonbinding, forearm loops that help the patient lift the walker for ambulation. Each handgrip of the paired attachments can be adjusted to the patient's positioning requirements.

For further information, write to Lumex Inc., 100 Spence St., Bay Shore, N.Y. 11706, U.S.A

Laparotomy sponges

A line of sterile, disposable laparotomy sponges has been added to Sparta Instrument Corporation's line of products.

Highly absorptive and lint free, the sponges are made of four-ply quilted cotton gauze, with an x-ray detectable element sewn into each sponge. They

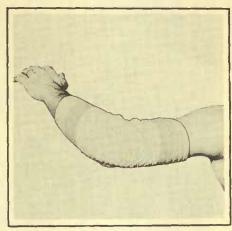
are available in four sizes with and without a radio-opaque ring, which is color coded for instant identification of size.

The sponges are double-wrapped with a peel-down outer envelope for aseptic removal. Five sponges are packaged per envelope, 10 envelopes (or 50 sponges) in each case.

Product literature and further information may be obtained by writing to Sparta Instrument Corporation, 305 Fairfield Avenue, Fairfield, New Jersey 07006, U.S.A.

### **Elbow sleeve**

Posey Company has introduced an elbow sleeve of polyester fabric, designed to minimize sheet burns. It may also



Elbow Sleeve

be worn on the knees to prevent them from rubbing together or to keep them warm.

Inquiries or orders regarding this product (No. 6221) can be directed to Enns & Gilmore Limited, 1033 Rangeview Road, Port Credit, Ontario.

**Tracheotomy tubes** 

Dittmar and Penn Corporation, Philadelphia, has announced a new line of stainless steel tracheotomy tubes.

"Tru-Arc" is the name of the new tubes, which are interchangeable within units of the same size. They feature ultra-thin walls for maximum passage of air through the cannula, welded construction for durability, and mechanical finishing to ensure smooth edges and corrosion resistance.

The Tru-Arc line comes in sizes one through nine in regular and short length. A choice of locks is also offered. The tubes are available in styles designed for use with standard 1.P.P.B. equipment, and can be adapted for use with respirators or fenestrated as required.

According to the company, precise mating has been achieved; this allows for the interchangeability of parts. For example, within units of the same size, an inhalation inner cannula will fit a Jackson Improved outer cannula. This will allow mixing or matching of parts.

### Stoma cap

The stoma cap, a new product from Hollister Limited, is a protective cover for an irrigation-controlled colostomy. It relieves gas pressure through a deodorizing filter (raised disc in photo), but absorbs mucus and other occasional secretions in a sealed, odor-barrier pouch.

About the size of a folded handkerchief, the stoma cap requires no taping, supplementary adhesive, or special skin preparation.

More information can be obtained from Hollister Limited, 332 Consumers Road, Willowdale, Ontario.



Stoma Cap

### Dermhydran powder

The Purdue Frederick Company (Canada) Limited, Toronto, has announced a new product, dermhydran powder.

This yellow powder forms a pale yellow suspension when mixed with warm water. Because of a special ingredient, a uniform film is formed when the suspension is applied to the skin. This film permits a more intimate contact of all components with the skin and helps retain the volatile agent.

Dermhydran powder produces a suspension that has a drying and mild dermal desquamating action, ideal for treating oily skin and its effects. With its use, the formation of comedones is reduced and the typical acne pimple dries and disappears within a few days.

The powder is indicated in all stages of acne vulgaris. It has been tried with success in a small number of cases of seborrhea, psoriasis, and lichen planus.

The contents of each I gm packet include 250 mg zinc sulphate monohydrate, 400 mg sulphurated potash N.F., and a binding agent. Contraindications are known sensitivity to any of its components. It should not be used with any topical preparation containing mercury, because of the formation of mercuric sulphide. The powder should be kept away from eyes and mouth. If undue skin irritation develops, it should be used less frequently or discontinued.

It is supplied in treatment kits that contain I gm packets of the powder, one measuring cup and stirring rod.

In Quebec, the agent for this product is Laboratoire Sigma Limitée, 6655 P.E. Lamarche, Montréal.

### Intensive care monitoring

Bourns Life Systems of California has introduced the Model LS112-2 respiration rate apnea monitor. Designed especially for intensive care monitoring, this model provides continuous monitoring and meter display of respiration rate; an audio and visual apnea alarm is adjustable for a 10 or 20 second delay. The alarm deactivates if the patient resumes normal breathing. An indicator light continuously monitors the condition of electrode-to-skin interface, with no switches to throw to test electrode continuity.

When properly attached to a patient, the meter displays average breathing rate, a panel light flashes with each detected breath, and audiovisual alarms alert personnel in case of apnea. The audio alarm volume is adjustable.

Complete specifications, price, and delivery are available from the Canadian distributors: E-I-L, Inc., 1565 Louvain St. W., Montreal 11, Quebec, and Mid-Canada Medical, 1244 Albert St., Regina, Sask.

### POSEY FOR PATIENT COMFORT

The new Posey products shown here are but a few included in the complete Posey Line. Since the introduction of the original Posey Safety Belt in 1937, the Posey Company has specialized in hospital and nursing products which provide maximum patient protection and ease of care. To insure the original quality product, always specify the Posey brand name when ordering.

The Posey "Swiss Cheese" Heel Protector has new hook and eye fasteners for easy application and sure fit. Available in convoluted porous foam or synthetic fur lining. #6121 (fur lining), #6122 (foam), \$4.80 pr.

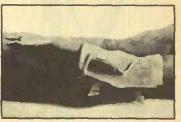


The Posey Foot Elevator protects pressure sensitive feet by keeping them completely off sheets. A washable flannel liner protects the ankle. Soft polyurethane foam ring with slick plastic shell allows patient to move his foot freely. #6530 (4 inch width), \$7.80.



The Posey Foot-Guard with new "T" bar stabilizer simultaneously keeps weight of bedding off foot, helps prevent foot drop and foot rotation. #6412, \$21.00.





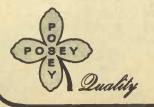
The Posey Elbow Protector helps eliminate pressure sores and friction burns. Three models are available. #6220 (synthetic fur w/out plastic lining), \$5.25 pair.



The Posey Ventilated Heel Protector helps prevent friction and skin breakdown while allowing free movement. The newly developed closure holds heel protector on the most restless patient. #6110 (w/plastic shell), \$7.80 pr.

Send for the Iree all new POSEY catalog - supersedes all previous editions.

Please insist on Posey Quality - specify the Posey Brand name.



Send your order today!

**POSEY PRODUCTS** Stocked in Canada ENNS & GILMORE LIMITED

1033 Rangeview Road Port Credit, Ontario, Canada

# Pampers Pampers Oives ouboth abreak

### Keeps him drier

Instead of holding moisture, Pampers hydrophobic top sheet allows it to pass through and get "trapped" in the absorbent wadding underneath. The inner sheet stays drier, and baby's bottom stays drier than it would in cloth diapers.



# Saves you time

Pampers construction helps prevent moisture from soaking through and soiling linens. As a result of this superior containment, shirts, sheets, blankets and bed pads don't have to be changed as often as they would with conventional cloth diapers. And when less time is spent changing linens, those who take care of babies have more time to spend on other tasks.

PROCTER & GAMBLE

## The patient as an equal partner

Whether it is in a one-to-one or in a group relationship, the professional in community mental health must help the patient become a full partner on the team. The author explains why token power is devastating for a patient's self-esteem, and describes problems with therapeutic communities she has seen.

Gertrud B. Ujhely, R.N., Ph.D.

In this paper I will look at the patient as a partner on the health team in the following three roles: as a partner with the professional in the therapeutic relationship, as a member of the therapeutic community, and as a representative of the whole community.

### Patient as a partner

When I speak of a therapeutic relationship, I do not necessarily mean only formal psychotherapy or analysis, but all those interactions between the staff and the patient that are supposed to lead the patient toward improved health. There are, of course, two sides to a partnership. Whether we are basically willing to engage in a partnership with patients may largely depend on our basic attitude toward them.

At the start of a therapeutic relationship, the patient is likely to present himself as someone who suffers and who sees himself as powerless to do anything effective about it. He expects us to remove what ails him and make him feel well as soon as possible. All the power he feels he lacks seems to be invested in us. Or, a patient may resent being under our care, for he cannot see there is anything wrong with him.

Both the patient's extreme submissiveness and extreme rebellion are symptomatic of the initial phase of the therapeutic relationship, when he has not yet assumed responsibility for his part. One cannot expect him to do so, as he still finds himself in a stage of emo-**IUNE 1973** 

tional development in which he is identified, to a large extent, with his pathology. Although he wants to get rid of his suffering or of his lack of freedom, he does not really want to

The professional must not accept the power handed to him by the patient or provoked in him by the patient's attitude of rebellion. This is not easy, for who among us does not want to be the personified healer who has the power to work miracles, or at least is seen as such in the eyes of the other?

According to Jungian theory, human beings can never become God-like, or become the personification of the "great healer." All we can do is become aware of the healing principle in each of us, including the patient. This healing principle is bipolar, consisting of the wound and the healing force.

If we allow the patient to endow us solely with the power of healing, we allow him to project his own healing force upon us; at the same time, we get rid of the suffering pole in ourselves and project it on him. This makes him

the suffering one, while we enjoy superhuman power at his expense.1

Furthermore, if we succumb to the flattery, we succumb to a kind of selfinflation or exaggerated pride. If we are to preserve our image of the "great healer," the patient had better improve, and improve fast. If he has some sense, he will try to get out of our clutches. Or he may have to hide his pathology, for fear we shall be disappointed. It does not take much imagination to realize such action can have disastrous results in the long run.

On the other hand, if we can see ourselves and the patient as truly human, we can empathize with his suffering through our own capacity for experiencing pain, and we can evoke the healing powers in him by trying to serve the healing principle in ourselves. This establishes a genuine partnership between us and the patient, in spite of his apparent lack of responsibility. This way, the patient will sooner or later move from the initial phase and realize his condition did not simply happen to him, but that his own attitude toward life and toward himself and others had quite a bit to do with his plight.

In the second. or "ethical phase,"2 both patient and professional experience their partnership. The patient assumes responsibility for his work with the therapeutic agent and begins to use him as consultant and validator, rather than as the great authority.

The author is professor and director, graduate mental health-psychiatric nursing program, at Adelphi University School of Nursing in Garden City, New York. Her article is adapted from the paper she presented in October 1972 at a McGill conference on psychiatric nursing.

Here, too, the person treating the patient may not like to be seen as merely another human being, one with more knowledge and experience, perhaps, but still devoid of the halo around his head or the devil's horns. If he needs the glory to compensate for his own feelings of inferiority, he is likely to try to keep the patient in his previous bondage and discourage any clumsy attempts by the patient to establish a two-way relationship.

If the professional can accept the patient's forward movement, he will find the patient has begun to move into the next and culminating phase — "the religious" one.<sup>3</sup> In this phase, the patient realizes he can assume responsibility for his attitudes and actions, but not for what happens to him, nor for the pains he must endure. He begins to realize there are powers greater than his own ego, upon whose grace he must draw.

When the patient has reached this phase, the partnership can continue, but the roles between therapist and patient will have changed again: both serve the healing principle consciously in a joint endeavor. Since it is difficult in our society to talk about one's spiritual experiences, the therapist might serve as the one person with whom the patient can fully share his feelings without needing to be afraid of ridicule or of misunderstanding.

Here, too, there is danger. The therapist may not be willing to accord the patient the glory, as he sees it, of depth experiences of this kind. He may want to preserve the privilege of enlightenment for himself. Or, he might not have the capacity to experience powers beyond those of his own ego and may not appreciate what the patient is going through.

### Patient in therapeutic community

With the first use of tranquilizers, some 20 years ago, we came to be a little less afraid of patients' actual or potential violence. In addition, a general reaction to political restrictions in the early tifties in this country and to work done abroad, especially in Eng-

land, gave mental hospital administrators the idea that patients should have some say in the decision making concerning them. Actually, the staff usually made the decisions, but patients were at least told their requests were unrealistic. In matters that did not really affect policy, patients were allowed to make decisions.

Token therapeutic communities—in which patients are told they are full partners on the health team with a voice in decision making, yet have only a pseudo voice—perpetuate the confusion and deception that led to their condition in the first place.

Those responsible for instituting therapeutic communities must be clear about the extent of the patients' decision making in the administration of the community, and must communicate their intent to the patients. A clear spelling out of the parameters of the patients' freedom, which may be determined by the staff alone or in conjunction with the patients, is, in the long run, more important for the patients' mental health than the degree of freedom they actually have.

Token power is devastating for the self-esteem a patient might still have, as it implies he is not being taken seriously and is treated as a child to be calmed down at any price.

There are serious issues involved in giving the patient full freedom of determination on the interdisciplinary team. Besides, he does not make decisions only for himself. If the therapeutic community is a genuine one, he is also called on to make decisions concerning other patients, decisions that may involve visiting privileges and even discharge of patients from the unit.

The problem with the therapeutic communities I have seen is that the staff does not trust the patients. Because the patient does not function properly in some areas and lacks judgment, he is considered unable to function in any other area. I believe this assumption is a fallacy. I know of many examples where patients showed not only excellent judgment and responsibility where their companions'

fate was concerned, but also could affect their behavior much more quickly and deeply than the staff had been able to do.

If there is a genuine therapeutic community, the patient will, before long, experience the support of his peers and the staff as a force that surrounds him from the outside and helps pull him together within. He may perceive the others as the roots of his own damaged tree, and before long will begin to grow his own roots.

Instead of feeling powerless, as he likely did in the situation that caused his illness, the patient now feels he can influence his environment. Or, instead of having to be afraid of his unlimited power over the members of his family, which scared him half to death because of its potential of unlimited violence, he now feels a secure ring of benevolent forces around him, forces that will recognize his voice while raising their own in an attempt to balance his for the good of the whole.

At first, staff are seen as all-powerful, unapproachable, or too busy to care. But, just as with individual patients, the staff do not have to impersonate this image. Nor do they have to be quiet if they disagree with what the patients say, for fear of intimidating them. They must learn to trust in the group's reasoning power and in its healthy balance of judgment, in spite of individual patients' pathology.

Why do groups lose control? It is important for the staff, together with the patients, to set up norms that are genuine and workable. Further, it is important that these norms be continued in spite of attribution or additions of staff and patients.

If group cohesion is strong, one disruptive person can probably be absorbed into the atmosphere and is likely to change gradually under group pressure. But if cohesion is poor, if there are factions among the group, or if the overt messages do not coincide with the covert ones, one newcomer with a different ideology can disrupt the entire ward.

It is the professional's responsibility

to be alert to problems in communication and group cohesion. But that does not mean he carries responsibility for the therapeutic community as such. This he must share openly and wholeheartedly with the patients.

### The community and the professional

In community mental health, problems abound over the issue of equal partnership between lay persons and professionals. The overall themes of love of power and mistrust are mutual.

Different kinds of communities and different problems can be found. For example, there is the community that is so passive it does not make use of mental health programs and facilities. On the other hand, there is the highly belligerent community that is unwilling to relinquish its confrontation tactics and begin a dialogue with well-meaning professionals. There are situations where the professionals plan programs and offer them to the community, and others where the community makes demands the professionals do not recognize.

The neediest community is often the one least equipped to express its needs in a way the professional can understand. This reinforces the professional's belief that the community is ignorant, has neither the training nor understanding to appreciate its problems, and therefore should listen to the expert.

In many cases, the members of the community lack sophistication and do not dare expose their ignorance before the professional. We must help them reach a point of awareness and level of objectivity and abstraction that will enable them to communicate their needs in a way intelligible to us and others.

In many cases we may have to educate our clients before admitting them to equal partnership in the healing process. This does not mean, however, that we usurp responsibility for the therapeutic process or the programming of services, or that we are the active agents and our clients the passive ones. Such an attitude on our part is not easy, **IUNE 1973** 

for it requires respect for something that is not yet evident.

Some professionals make the opposite error by giving the community responsibility it cannot yet assume. They treat their clients as if they were already prepared to assume full partnership, even though they still need some education to express their needs. The cause of this dilemma is the misconception that only one or the other has the power of decision making, that either the professional must do what the community says or the community must do what the professional says.

Is it not rather a matter of dialogue, in which each must say what he sees and each must respond to what the other says, after having allowed himself to be affected by it as fully as he can bear? This is not easy if the professional sees himself as the sole expert; nor is it easy if the community sees itself exploited and misunderstood by the professional.

The professional must use all his knowledge of group process to keep communication open and discussion moving. Even then, it does not always work. If the professional has done everything he can, he may learn from his failure. The fault may not be all his, for his good intentions at dialogue may have been diverted into a confrontation of powers, which is the style of our day.4

Another problem lies in a confusion of the roles of professional and community. The professional is an expert in his field, but this does not entitle him to determine the values and priorities of the community. He can try to influence them in light of his knowledge and values, but the decision about programs is legitimately the community's. On the other hand, it is up to the expert to judge how programs should be implemented.

The outcome of this confusion of roles depends largely on the human relationships that can be established as underpinnings of the program structure. If the relationships are solid, trusting, and allow for dialogue, they will carry the program; if they are tenuous, suspicious, and hostile, the programs will likely collapse, no matter how good they look.

### Conclusion

I have attempted to draw some pictures of the partnership between the patient and the professional in the mental health field. I have spoken of the danger of inflation on the part of the professional, of his mistrust and implied derogation of the client's potential, and of the role division between the layman and expert. I hope I have made it clear that even when the patient is not ready to carry his full load, partnership is not only possible, but is essential in the healing and health process, whether it be in the one-to-one relationship, the therapeutic community of a unit, or the community at large.

### References

- 1. Guggenbuehl-Craig, Adolf. Power in the helping professions. New York, Springer, 1971.
- 2. Frank, Margit van Leight. Stages of the transition in the development from the infantile to the cultural psyche. A paper read at the Analytical Psychology Club of New York, 1963.
- 3. Ibid.
- 4. Bandler, Bernard, ed. Psychiatry in the general hospital. Boston, Little, Brown, 1966.

## Red Cross outpost nursing in New Brunswick

The personal memoirs of an outpost nurse — 25 years later.

Kathleen G. DeMarsh, R.N., M.Sc.N.

As a nursing student at the Saskatoon City Hospital, I was assigned the care of a patient who had done outpost nursing in Saskatchewan. I remember being fascinated with her stories, resolving that at some point I would explore the possibilities of outpost nursing.

About five years later, when I was director of nursing education at a school of nursing in Ontario, I received a letter from my brother, a theological student, asking if I would be interested in opening a Red Cross outpost at Miscou Island, New Brunswick, where he had been assigned for summer experience.

This was in 1946. There was no doetor on the Island. My brother had been in touch with the provincial division of the Red Cross and had found they needed a nurse. As well, he had located a house at the harbor, which could be used as a nursing station. Would I be remotely interested?

I responded immediately that 1 would be interested. Soon after, I received from him a clearer picture of what would be involved.

There were 1,300 people on the island, 90 percent of whom were French speaking; a further 3,000 people lived on Shippegan Island. Two channels of water had to be crossed before arriving on the mainland. There was no access to the outer island for two weeks in the spring and fall, when the ice broke and formed. There were no electric lights on the island, and only two telephones.

I wrote back saying I was still interested. A short time later I received a wire from the New Brunswick division of the Red Cross, advising me I had been employed at a salary of \$100 a month, my duties to commence as soon as I could come.

### Willing to learn

Shortly after my appointment as Red Cross nurse, I was invited to attend a meeting in the local school house on the island to meet some of the people. During the meeting, a very vocal French-speaking resident indicated in no uncertain terms his dissatisfaction

The author, who later worked with the Canadian Red Cross as Director of Outpost Hospitals and Nursing Services in Saskatchewan and as Assistant National Director of Nursing Services, is now Vice-President (Nursing), Health Sciences Center, Winnipeg, Manitoba.



with the Red Cross in their selection of an English-speaking nurse. "Over 90 percent of the people speak only French," he said, "and the women who need the nurse most do not speak any English at all." Undaunted, I approached this gentleman following the meeting and told him that since I was already appointed, I had no intention of resigning. If he would teach me to speak French, I would be willing to learn, I said.

l arrived on the island in the fall, full of enthusiasm, but with a minimum of supplies. I set about unpacking and sorting out what supplies I had. There were several large, war-time parcels from the Red Cross, including medical supplies long outdated, any number of water pails, pitchers, glasses, plus 48 dozen tins of Campbell's vegetable soup!

The small white house at the harbor, selected as the nursing station, had to be completely cleaned. Patients began to arrive almost immediately by foot, bicycle, or horse-drawn buggy, to seek advice, assistance, or simply to see what the new Red Cross nurse looked like and what she had to offer.

These were busy but exciting days. I soon discovered the need to have at least two fully equipped "baby bags" on hand for immediate action. I made

endless trips to the harbor, where I called the doctor on the mainland about patients' needs. In many instances I had to proceed according to my own judgment following examination of patients, and then report to the doctor after the fact.

At the end of one month, the Rothesay branch of the New Brunswick division of the Red Cross made arrangements to purchase a horse, "Nellie Rothesay," which was to be my means of transportation. When the islanders learned that the Red Cross nurse was to be equipped with a horse, they set about with great energy and much care to prepare the barn for the horse's arrival — even papering the cracks with cardboard. I wondered if this were a measure of my acceptance by the islanders. At any rate, it seemed to me that in a short time I had won their confidence and support, and certainly they had won my respect and admiration.

### A good winter for gossip

On visits to one or other of the islands, I would often find a whole series of families suffering from influenza, diarrhea, or some other ailment. Frequently, because of a storm, it would be necessary for me to stay overnight. And in every instance the

islanders did their best to make me comfortable and at home.

During that first year, it seemed that every home I visited would have more than its share of neighbors who would come to call, presumably to get a look at the nurse. I remember an instance in which one man looked me up and down, dressed as I was in parka and slacks for winter, and then said, frankly, "My God, you are tall! I've never before seen so tall a woman!"

Often when I would go into the local store to purchase supplies for the nursing station, the pot-bellied stove would be surrounded by local fishermen discussing the latest news. Undoubtedly, the advent of the first Red Cross nurse on the island made it a good winter for gossip.

Since the island people had never had available any type of local medical service, it was understandable that news would spread concerning actions the nurse had taken and her seeming successes and failures in treating people. Penicillin was fairly new at the time, and I remember some rather dramatic intramuscular injections of this drug. After these "miracles," as they were perceived to be, I would get a whole series of patients coming to the nursing station with long-term back pain, aching joints, and so on, absolutely convinced

THE CANADIAN NURSE 25

that "that needle" would cure them.

I continued to do the best I could. In many instances, I found myself making judgments and taking action that in normal situations I would not have dared to make or take!

Although I always had access to the doctor on the mainland, I usually called a doctor in Bathurst, approximately 100 miles away, when I was really in doubt about a patient. I didn't meet this man until the following year, but I had a tremendous sense of confidence in his ability to make a differential diagnosis and relieve me of the awesome burden of what to do next for a critically ill patient.

### **Emergency care**

On one occasion I remember a man driving his sleigh to the door, then coming in and asking if I could come quickly to the other island to visit a seriously ill woman. He had no idea what the problem was, and could tell me nothing more than that I was needed urgently. On impulse, I picked up one of the "baby bags" as well as my regular kit, and off we started across the ice by sleigh.

When I arrived in the patient's home, I found her barely conscious, surrounded by 10 to 12 neighbors who were bemoaning her fate, but doing nothing to assist her. Her husband was sobbing.

The woman had obviously had a spontaneous abortion. Her pulse was barely perceptible, indicating she was probably still bleeding. I raised the foot of the bed, put an ice pack on her abdomen, made her as comfortable as possible, and then began to think of alternate ways to restore her consciousness or at least her pulse. I don't recall the exact measures 1 took, but I do know that at one point I realized her only hope for survival was a blood transfusion. At the same time I realized she would probably not be able to survive a trip to the hospital, one hundred miles from her home.

I remember making several attempts to get from the patient's house to the house across the road so I could telephone the doctor. I had given the husband a white diaper to wave so I could come back immediately if there were any change in her condition. When I finally made it to the phone, I found the doctor most helpful. He established the exact location where a plane could land, then advised me the approximate time I could expect medical assistance. I directed some of the neighbors down with lanterns to wave the plane in, while I continued to care for the patient.

When the doctor finally arrived, I remember him saying he had never seen a woman so blanched and yet still alive. He started a transfusion immediately, provided me with directions for her care, left the medicines I would need, and gave me the reassurance I required to earry on, before he departed by plane into the darkness of the night.

I am happy to report that this patient gradually recovered. About one year later I delivered her of a healthy male child.

One other occasion that comes vividly to mind is a phone call I received from the priest, saying there had been a shooting accident and the victim's hand had been badly mutilated. The island was inaccessible at the time, so a local resident (who had been trained as a licensed practical nurse) and I set about to get emergency supplies ready. We ended up suturing the man's hand in the kitchen of the nursing station, using obstetrical sutures following the administration of morphine to ease his pain, and putting sulfathiazole powder in the wound to prevent infection. I believe we administered whiffs of chloroform, all without a doctor's order. But after all, this was an emergency! The phone was one and one-half miles away, the island was inaccessible, so what else could we do?

Because of the severe mutilation

of this patient's hand, I feared gangrene might set in. For the next two weeks I visited his home by sleigh daily to observe the process of healing and to change the dressing.

By the time it was possible for the patient to visit the doctor on the mainland, I was relieved to note that healing seemed to have progressed normally without infection. The only problem was that the patient's middle finger wouldn't straighten out; nor could he close his hand. When he told me the doctor had advised him to have the finger removed, I objected strenuously. After all, hadn't I saved his hand?

I begged the man to let me work with him throughout the summer months to see if we couldn't get some flexibility into the finger before he decided to have it removed. I initiated a daily regimen of exercises for him, followed by regular massaging with warm oil. He visited the nursing station on a weekly basis for assessment, encouragement, and support. By fall, he was able to straighten and close his hand, and although the finger remained somewhat stiff, he did not have to have it removed.

### Nellie replaced by Chevvy

At the end of one year, I had come to the conclusion that unless certain changes were made, I would not stay longer. When the director of outpost services visited, I told her what we needed: a telephone in the nursing station; a second nurse; and a car.

As these conditions were met, I decided to remain for a second year. At this point, a French-speaking nurse from Bathurst joined forces with me. Since she did not drive, we usually made calls together. What a joy it was to have her with me for company and consultation, as well as for assistance!

The telephone in the nursing station made a tremendous difference in my ability to contact the doctor on a regular basis. One thing I neglected to notice was that the installation of the tele-



The hot-stove league were provided with a new source of information: the telephone cable had been hooked up to the radio in the local grocery store.

phone had been observed by many of the fishermen at the harbor. Imagine my surprise, during one lengthy ride by sleigh, to discover the driver repeating almost verbatim the content of a telephone call I had made to the doctor about one of my patients. When I questioned him further, he volunteered the information that the cable had been located and hooked up to the radio in the local grocery store.

In other words, the hot-stove league had been provided with a new source of information and gossip, which became particularly distressing when the calls were personal and the patients known. Fortunately, a call to the main telephone operator resulted in a private line being established — a considerable cost to the company, but a great relief to the nurses!

The advent of the car—a brand new Chevrolet right off the assembly line - made it possible to extend our services immeasurably. We were able to plan regular prenatal visits, get patients into Bathurst for chest x-rays,

take critically ill patients to hospital, and make follow-up visits to older patients to check on their diets and supervise their health care.

### Conclusion

I am convinced that only through personal experience can one fully appreciate the significance of the work of the Canadian Red Cross. Its philosophy of moving in to provide a service in response to need, then continuing that service only until another agency takes over, has always appealed to me as being sound and as keeping the Society flexible in a time when needs and resources can change so rapidly.

I have long believed that the Red Cross outpost nursing service fills an invaluable need, while at the same time giving its nurses an opportunity to function at a level they would not otherwise dream possible. The point I would like to make has relevance, I believe, for the dilemma facing the nursing profession today. I have often asked myself, following my outpost nursing experience in New Brunswick, whether or not society as a whole is prepared to allow the nurse to function at her full capacity. And if not, why not? Why, for instance, was I able to do so much for patients in an outpost setting that I would not be allowed to do in an urban setting?

I believe that patients today, wherever they may come for assistance, are less interested in the category or the sex of the person to whom they come for help, than they are in the compassion and competence of the persons who provide that help. Is there a lesson here that could be learned in relation to the proposed community health clinics? If so, perhaps Canada's Red Cross nurses can be counted on to contribute richly to the development of such clinics. Certainly they have a unique contribution to make that should not be discounted by the official and unofficial bodies charged with the development of new systems of health care.

# Staff nurse involvement in research

# myth or reality?

Is staff nurse involvement in research only a bandwagon theme, or is it a practical necessity? A look at a few of the myths and realities surrounding some dimensions of research as they pertain to staff nurses can help us answer this question.

Shirley M. Stinson, R.N., Ed.D.

This article is intended for nursing administrators, educators, and researchers as well as for staff nurses, since the degree to which staff nurse involvement in research is myth or reality depends not only on how staff nurses perceive that question, but also how others perceive it.

### What is Nursing Research?

Myths: Nursing research is a highly scientific enterprise carried out by a trained few.

Realities: If we look at nursing research as a "thing," a tangible product, such as a report, an article, or a book, a reality is that few staff nurses seem to be involved directly; if we view it as a systematic, detailed process, it is still a comparative rarity for practitioners, including staff nurses, to participate directly in designing and/or carrying out research studies. But if we think of nursing research in the sense of its being an attitude, what are the realities?

First and foremost, research is an attitude. This is, and has been, a major theme in the literature: being a professional implies being a person who

Dr. Stinson is Professor and Senior Health Research Scientist, Division of Health Services Administration, University of Alberta, Edmonton, She is also Chairman of the Canadian Nurses' Association's Special Committee on Research.

constantly tests ideas and approaches and persistently tries to explain why the ideas are or are not valid, and why some approaches work under certain circumstances and some do not.1

Is it a myth to think that most staff nurses possess a research attitude or is it a reality? Much research centers around specific hypothesis testing. For example, "patients given preoperative teaching will have a shorter hospital stay than comparable patients who do not." In a more general way, we can think of a hypothesis as a question: "I wonder what would happen if . . . ?"

Although to some extent we know beginning answers to such questions as "what would happen if helpless patients are left unturned for long periods ...." we do not know much about what would happen if medicare payments covered nurse practitioner services in doctors' offices, or what would happen if all nurses were capable of and would give active support to dying patients and their families. Nor do we know what would happen if hospital and public health nurses had authority to make direct patient referrals to one

Is it a reality that most staff nurses employ a "research attitude" in their day-to-day practice? This we do not know. What we do know is that most staff nurses have had little preparation in the art of problem solving, an inherent part of research attitudes and practices. But even with nurses prepared in problem solving, there is some evidence to indicate that they soon lose much of their tendency to try new ideas or take professional initiative.2

Why? Any nurse is subject to the values and pressures of the people with whom she works, particularly her peers. Further, if nursing service administrative staff turn thumbs down on the questioning staff nurse, she is likely to retreat to the status quo. I have known sound research ideas to emerge from staff nurses, only to be quashed by their supervisors and/or nursing directors. But there is another side to this coin: I have also known nursing administrators to respond (they are, after all, human!) when staff nurses hold on to the value of testing new (and challenging old) ideas.

Whether we regard research from any of the standpoints of product, process, or attitude, the need for full-time "trained researchers" is a reality; but these people, however necessary, constitute only a tiny and insufficient portion of the research component of any profession. Ultimately it is practitioners who produce a truly research-oriented profession.

### Is Research "Practical?"

Myths: Nursing research, including a research attitude, is impractical. It is a luxury item. What really matters is

getting today's work done.

Realities: Much research, including nursing research, may have relatively low immediate payoff. For example, if systematic study indicated that what student nurses are taught bears little relation to today's service needs, the immediate payoff from that type of research would be relatively limited; the big "practical" job, that of re-designing curricula, retraining faculty, and upgrading practitioners' knowledge, would still need to be done.

But low immediate payoff from nursing research need not always be true. Let's look at an example of a study in which the payoff potential was staring us in the face: It is now four years since Poole published her definitive study of TPR's3; yet, to my knowledge, few hospital nursing departments have applied her findings - findings that could not only save nursing time, but could also improve the accuracy of nursing care.

The above example of a "researchpractice gap," that is, of lag between the publication of research findings and the business of implementing the findings is, in principle, not unique to nursing; this problem exists in one form or another in all professions. But that does not make the problem any less serious in nursing. There is not much point in producing more and more research findings unless we make provision for implementing them; otherwise nursing research is not practical in terms of giving direct patient care.

### What Kinds of Research are Needed?

Myths: Only experimental research is needed in nursing. Further, unless a researcher employs complex statistics, his research is not really scientific.

Realities: Of the three basic research approaches: survey, historical, and experimental, all are applicable in nursing.4 According to Fox, the survey (descriptive) approach, particularly in relation to function studies, has been the most widely employed to date. (An example of the survey approach would be time and activity studies on what head nurses and staff nurses do.)

The reason the survey approach is so important is that only through systematically describing events can we become aware of the crucial components in those events.5 We think we know quite a bit "for sure." But do we? For example, we "know" that mothers of stillborn infants need support from nursing staff; but a systematic description of nurse-patient interactions in your hospital or health unit might indicate, as Field found in her study, that nurses tend to avoid those patients.6

Taking this illustration to its logical opposite, it is also possible that there are some factors operating in your institution or health unit that tend to yield an entirely different picture: perhaps in your agency these mothers do get the support they need. But we must



ascertain that sort of thing — not assume it.

Through careful and extensive description of nursing care systems and situations, we can identify which components we might best try to modify (that is, experiment with) in an attempt to improve nursing practice. Staff nurses can play a vital role in descriptive research, for they are far more likely than most researchers to be familiar with the clinical intricacies and special problems of direct patient care in their specialty areas.

In general, as we move from describing the nursing care of one hysterectomy case, for example, to, say, a hundred hysterectomy patients, the use of statistics becomes greater. But even "large" studies do not always require the use of statistics. It is as mythical to think that "nonstatistical" research is unscientific as to think the reverse.

The principle to keep in mind is that if statistical techniques help us to examine and interpret the data more meaningfully, we should use them; if not, it is not only silly and pedantic to employ them, but also misleading.

Along these lines, it is important to realize that one of the most difficult parts of research has also nothing to do with statistics: the identification of meaningful, "researchable" ideas. Although often a complex, skill-demanding business, the subsequent development of the design of a study (including the question of appropriate statistics), is necessarily a secondary matter.

Some think of historical research as being irrelevant. But is it? Phenix says persons who have no interest in the past are, in effect, denying the significance of the present. Historical nursing research can take many forms, not the least of which is the recording of first-person accounts.

There is currently a hue and cry that staff nurses should give "direct" nursing care. There are several thousand older nurses, still living, whose whole earlier nursing experience was in the realm of direct patient care. Yet, it would now seem that the bulk of their valuable insights and recollections will be lost, not only to nursing, but

also to society, for lack of encouragement to put their experiences down in writing and/or failure of nurse researchers to see the experienced, almost-retired nurse as a valuable data source.

Another form that historical research can take is the writing of current history. For example, through writing about their recollections and impressions, nurses who worked with patients who had the first legal abortions have much to offer new graduates who take this practice for granted. Staff nurses now practicing in expanded roles in community clinics have much to offer to historical nursing research, if they would record and publish observations and insights about the conflicts and compatabilities they experience in working with other health professionals.

Too, there is historical value in securing, labeling, and safekeeping artifacts that are so easily taken for granted. Tomorrow's society may look with wonder on the glass syringe and the Thomas splint in the way we now look at feeding cups and alcohol lamp needle sterilizers. Artifacts do not constitute historical research per se, but they assist in conserving and transmitting values and practices of the past — and that is the essence of history.

Many of today's staff nurses still have copies of what are quickly becoming rare textbooks: their own and/ or others' passed down to them from older nurses. These can be valuable to researchers. Nursing historians often rely on earlier texts in tracing the development of nursing knowledge, and nursing librarians are continually trying to improve their collections.

The Canadian Nurses' Association's library has a fine beginning collection; but rare copies are still needed, as is true to an even greater extent with university nursing school libraries.

What may also not be obvious, yet valuable from a research standpoint, is the careful preservation of documents, many of which might seem currently useless: original minutes of staff nurse association meetings, a staff nurse's account of a hospital disaster, an actual nursing care plan,

and a copy of the staff nurse evaluation form. It is from such threads that the fabric of nursing history can ultimately be woven.

Experimental nursing research requires controls that are difficult to implement; further, the problems in this type of research are intensified by lack of adequate instruments to measure change.8 But the staff nurse is frequently involved directly or indirectly in experimental research. She may be a "subject" herself, such as in Hibberd's analysis of staff attitudes toward the compressed work week; her observations can be of crucial importance in "double blind" tests of therapeutic drugs and different types of nursing interventions; she can also be an originator of ideas for the conduct of experiments.\*

Throughout the health care system, in all kinds of research the staff nurse has a particular role to play in relation to the protection of human rights, including the right to privacy and the right to informed consent. This is a crucial role in research and one that the staff nurse, due to her close contact with individuals, patients, and clients, can and must shoulder.

## Is All Published Nursing Research Reliable and Valid?

Myths: Yes, or the research would not be published.

Realities: No, and there are several reasons why this is so. First, much nursing research — as is true for other types of research — is only of an exploratory character and the findings

\* Hibberd, Judith. "Compressed" work week for nursing staff: a field experiment. Edmonton, 1972. (Thesis(M.H.A.) — Alberta)

Bendall, Eve. Nurses and research. *Nurs. Times* 66:49:181-4, Dec. 3, 1970. (Occasional paper)

Russell, J.K. The midwife's role in research projects. *Midwives Chron.* 85: 1003:276-7, Aug. 1971.

Ellis, Rosemary. The nurse as investigator and member of the research team. *Ann. N.Y. Acad. Sci.* 169:435-41, Jan. 21, 1970.

are not definitive. Second, the research design of some studies, many of which appear credible at first glance, is so weak that the findings and conclusions cannot be trusted.\*\* Third, one must not automatically make generalizations from a study in one hospital or community agency to another. There may be too many other factors, not accounted for in the research study, present or not present in a second institution, which make the application unsound.

Fourth, the investigators may have used inappropriate statistical methods to analyze their data. <sup>10</sup> Fifth, the conclusions may be unsound. An example of a humorous non-nursing study involved a researcher who found that all his subjects who drank rum and ginger ale, scotch and ginger ale, gin and ginger ale, and rye and ginger ale felt "tipsy." He concluded that it must be the ginger ale that was the cause, for it was the only (so far as he could see) "common" component.

In short, it is as foolish to assume that all nursing research is reliable and valid as to assume that none of it is worthwhile. Yet it is sometimes not easy to make that distinction.

# How Can The Interested Staff Nurse Learn More About Nursing Research?

Myths: Only education at the doctoral level can equip you for research. An "opposite" myth is that everyone should just go ahead and do research and that special training is not really needed.

Realities: If nursing research in Canada were left to those nurses with doctoral degrees, there would be only about 20 persons to do it. Furthermore, the research skills of many persons with doctorates (inside nursing or without) are necessarily limited: some may be skilled in surveys or history; others in statistics and/or the experimental method; and the research experience

of some may have been restricted entirely to their doctoral dissertations.

Three other realities are that most of these nurses are engaged in teaching and educational administration. They are not, by and large, expert clinical nurses, that is, expert in the giving of direct patient care in hospital and/or community nursing areas. Also, many are to a greater extent researchers in the disciplines of sociology, biology, education, and so on, rather than being nursing researchers per se.

Where does this leave the staff nurse? If these persons with the greatest amount of formal research training are few and are necessarily limited both in terms of research skills and time for research, then what is the staff nurse, whose education has largely not included research even at an introductory level, supposed to do? Let us consider some of the things she *can* do.

First, she can ask herself, "Do I employ a 'research attitude' in my day-to-day work? Do I respond positively to others who do?" Then she can start to check those questions with her peers, her supervisors and subordinates—and perhaps indirectly with her patients.<sup>11</sup>

Too, the staff nurse can look at "things." It is a well-known fact that there are several electrocution deaths annually in hospitals due to faulty equipment, including inadequate ground wires and fuses. But who questions these kinds of things?

Mancino and Harmon report from their small study an average (for all the patients they studied) of 2.3 visitors per patient per day. Does it matter if we have any idea of what the "average" is in our hospitals? Try asking some of your co-workers and patients.

The process of *doing* research at whatever level is of unquestionable value. The mere act of systematic observation can open our eyes to other, quite unrelated, events. The "doing" may be that of writing a single case study, or keeping track of the average number of analgesics given to cholycystectomy patients during a certain period postoperatively. Or, it might be finding out what proportion of women in a section of your health unit want

information on family planning. The point is that unless we make a conscious effort to notice such things, we are unlikely to come up with new insights and better approaches.

A young staff nurse completing her baccalaureate degree recently asked me, "How can I get the staff nurses I work with interested in nursing research?" The question was turned back to her. She answered, "Well, we could start by discussing one nursing research article a week, but we don't know how to examine it critically to know if it is sound research. We might find an article interesting, but we won't know if we should change our nursing practice on the basis of it."

This poses a problem. For one thing, while this nurse had in a few short weeks developed some useful beginning skills for evaluating research articles, she was by no means "home free." For another, relatively few nurses have university preparation and many who do may have had the odd course in statistics, but be completely at sea in being able to read with a critical eye.

Learning about research is really a lifelong process; thus, regardless of one's initial preparation, there is always a need to continue learning about research skills. Few continuing education programs have reflected this reality, and nurses who want credit and/or non-credit nursing research courses or workshops should voice their concerns if they want to learn more.

What kinds of resources for discussing research reports might be available to an interested staff nurse group? Many nursing faculty members can be of assistance, as can sociologists and educational researchers, depending on the nature of the research being examined. In some cases the research skills of laboratory personnel, particularly in large hospitals, or epidemiologists in government positions, are relevant. Interested nurses can and should assess these resources in their own locale.

Books and articles can also be of direct help to the staff nurse or groups of nurses. Wandelt, Fox, Leininger, Abdellah, and Parkin are five authors of particular note. 13 It is through re-

<sup>\*\*</sup> For example, suppose you read that 28 percent of nurses who have tried team nursing do not favor it? If the researcher has not controlled for those who do use team conferences and those who give it only lip service, is the 28 percent really meaningful?

sources such as these that one can begin to see some of the central research problems, needs, and resources.

To date, there is no one place that a person can write to find out what research has been done on a particular subject; thus, we are compelled to search various sources to see what has been reported so far. Although this takes time and materials are often difficult to locate, the benefits can be great. For example, staff nurses who are interested in looking at patient-visiting patterns in their hospital could save time in the long run by first locating and discussing the Mancino-Harmon article I referred to.

Many research articles are not clearly written and are full or jargon. But as long as readers do not write editors and authors to register their dismay at this state of affairs, the situation is likely to continue. Even complex research can be described clearly.

So far as nursing research consultation services are concerned, these are relatively limited as yet in both Canada and the United States. Health and Welfare Canada provides research consultative services to health agencies through its health programs branch. Should nurses initiate a research proposal that is endorsed by their agency, research consultation can be requested from that resource. †

Sometimes the research "help" the staff nurse needs is money. There are many research funding resources available; one of the main problems is finding out where and under what conditions. So far as financial assistance for nurses interested in getting specific research training is concerned, the new national health grants program is providing monies specifically for that purpose. ††

To my knowledge, relatively few directors of nursing in hospitals or

community health agencies have had research experience. This situation can constitute a problem for staff nurses, for if directors do not take initiative in nursing research matters, it would seem unlikely that staff nurses will consider it a valuable pursuit. But is it not reasonable to expect that directors of nursing and inservice educators do and would respond to research interests and pressures "from below," 14 particularly if the interest is concerted? Things don't just happen, we have to *make* them happen.

### Conclusion

Although the myths would seem to support the idea that staff nurse involvement in nursing research is non-existent, impossible, and unattainable, the realities indicate that it certainly is a practical necessity. Without staff nurse involvement, nursing research is meaningless in terms of improved patient care. To what extent is nursing research a reality for you?

### References

- 1. Simpson, Marjorie. Research in nursing: the first step. *Int. Nurs. Rev.* 18:3:231-47, 1971.
- Kramer, Marlene. Role models, role conceptions, and role deprivation. Nurs. Res. 17:2:115-20, Mar./Apr. 1968.
- 3. Poole, Pamela E. A study of the routine taking of temperature, pulse and respirations on hospitalized patients. Ottawa, Dept. of National Health and Welfare, 1968.
- 4. Fox, David J. Fundamentals of research in nursing. New York, Appleton-Century-Crofts, 1966. p.180-208.
- 5. Ibid., p. 172.
- 6. Field, Peggy Anne. An analysis of student nurses' choices of selected nursing actions which could be utilized when caring for a mother following the birth of a stillborn infant. Seattle, 1968. (Thesis (M.N.) University of Washington).
- Phenix, Phillip H. Man and his becoming. New Brunswick, N.J., Rutgers Univ. Pr., 1964, p.101.
- 8. Fox, op. cit., p. 197.
- 9. Canadian Nurses' Association. Special Committee on Nursing Research.

- Ethics of nursing research. Canad. Nurse 68:9:23-5, Sept. 1972.
- Ellis, Rosemary. The nurse as investigator and member of the research team. Ann. N.Y. Acad. Sci. 169:435-41, Jan. 21, 1970.
- 10. Fox, op. cit., p.270-1.
- 11. Voda, Anna M. et al. On the process of involving nurses in research. *Nurs. Res.* 20:4:302-8, Jul./Aug. 1971.
- 12. Mancino, Diane J. and Harmon, Vera. Visiting trends and gift giving. *Nurs. Forum* 11:3:264-2, 1972.
- Wandelt, Mabel A. Guide for the beginning researcher. New York, Appleton - Century - Crofts, Educational Division/Meredith Corporation, 1970.

Fox, op. cit., p. 252-273.

- Leininger, Madeleine M. The research critique: nature, function, and art. In Batey, Marjorie V., ed. Communicating nursing research: the research critique. Boulder, Col., Western Interstate Commission for Higher Education, 1968. p.20-32.
- Abdellah, Faye G. Overview of nursing research, 1955-68, Part 1: Nurs. Res. 19:1:6-17, Jan./Feb. 1970; Part 2: Nurs. Res. 19:2:151-62, Mar./Apr. 1970; Part 3: Nurs. Res. 19:3:239-52, May/Jun. 1970.
- Parkin, Margaret L. Information resources for nursing research. *Canad. Nurse* 68:13:40-3, Mar. 1972.
- 14. Elfert, Helen Moogk. Clinical nursing research. Nursing Papers 2:1:8-12, Jun. 1970.

<sup>†</sup> Enquiries should be made to the Director General of Research Programs, Health Programs Branch, Health and Welfare Canada, Brooke Claxton Building, Tunney's Pasture, Ottawa, Ontario.

<sup>††</sup> See footnote above.

# Books you need for the nursing future YOU want.



# PERSPECTIVES IN HUMAN DEVELOPMENT

**Nursing Throughout the Life** 

### Cycle

Doris Cook Sutterley, R.N., M.S.N. and Gloria Ferraro Donnelly, R.N., M.S.N.

An entirely new approach to the study of human development, designed to prepare nurses to meet the challenges of the present and future, and to apply recent findings in the physical and social sciences to the care of patients. The authors stress a multidisciplinary, holistic view of man, the promotion and maintenance of health, and intervention in times of physical, emotional and social stress.

J. B. Lippincott, 1973

abt. \$7.95



### Carolyn M. Hudak, R.N., M.S., Barbara M. Gallo.

R.N., M.S. and Thelma Lohr, R.N., M.S.

A comprehensive course in the area of critical care nursing, unexcelled in depth and content. Material for the text evolved from the authors' four years experience in teaching intensive care nursing content in continuing education courses. The approach is holistic, based on the interrelatedness of the four major body systems — respiratory, cardiovascular, renal and nervous — with man's hierarchy of needs as a framework.

J. B. Lippincott, 1973

abt. \$9.95

# JEW!



# THE PRACTICE OF MENTAL HEALTH NURSING

**A Community Approach** 

Arthur James Morgan, Jr. M.D. and Judith Wilson Moreno, R.N., M.S.N.

Written by a nurse and a psychiatrist actively engaged in the practice of community mental health, content focuses on reality-oriented practice and the presentation of concepts basic to the delivery of patient care. The text reflects the dynamic quality of psychiatric care in the challenging community setting and the colleague relationship required of all professionals to achieve excellence in the treatment of emotionally disturbed patients.

J. B. Lippincott, 1973

flexible cover \$5.95

# THE PRACTICE OF MENTAL HEALTH NURSING A Community Approach

J. B. Lippincott, 1973 cloth \$7.50



### J. B. LIPPINCOTT COMPANY OF CANADA LIMITED

SERVING THE HEALTH PROFESSIONS IN CANADA SINCE 1897

75 HORNER AVE. TORONTO, ONTARIO M8Z 4X7 (416) 252-5277

### REPRESENTING:

Little, Brown & Company (Medical/Nursing), Boston Blackwell Scientific Publications Ltd., Oxford, England Springer Publishing Company, Inc., New York

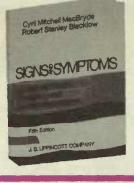
### LIPPINCOTT'S NO-RISK GUARANTEE

Books are shipped to you ON APPROVAL: if you are not entirely satisfied you may return them within 15 days for full credit.

BONUS OFFER WITH ORDERS OF \$25.00 OR MORE









### MEDICAL-SURGICAL NURSING

### **TEXTBOOK OF MEDICAL-SURGICAL** NURSING

Second Edition Lillian Sholtis Brunner, R.N., M.S. Charles Phillips Emerson, Jr., M.D.
L. Kraeer Ferguson, M.D., F.A.C.S. and
Doris Smith Suddarth, R.N., M.S.N.
Designed to develop the highest degree of

clinical expertise in the care of the medical and surgical patients, this book is outstanding in its depth of PATHOPHYSIOLOGIC content. It emphasizes the psychosocial factors involved in patient care and includes diagnostic evaluations, common laboratory tests, and orientation to operating room nursing.

J. B. Lippincott, 1970

### CARE OF THE ADULT PATIENT Medical-Surgical Nursing **Third Edition**

Dorothy W. Smith, R.N., Ed.D. Carol P. Hanley Germain, R.N., M.S. and Claudia D. Gips, R.N., Ed.D.

The focus is on nursing with consideration given to the individualized care required at various stages in adult life along the healthillness continuum. This book reflects the authors' philosophy, i.e. warm, compassionate care firmly grounded in the biological, social and behavioral sciences.

J. B. Lippincott, 1971

### ADVANCED CONCEPTS IN CLINICAL NURSING

Kay Corman Kintzel, R.N., M.S.N.

This is the first book designed specifically to assist the nurse in developing expertise in the more complex aspects of clinical nursing. Presents an in-depth study of sixteen areas requiring sophisticated nursing intervention.

Included in the 16 areas covered: Family Planning; Intensive Care Nursing; Mechanisms of Shock (Pathogenesis and Nursing Intervention); Water and Electrolytes in Health and Disease; The Immune Reaction (Nursing Intervention for Allergic Patients). J. B. Lippincott, 1971 \$14.50

**TEXTBOOK OF PATHOPHYSIOLOGY** W. D. Snively, Jr., M.D., F.A.C.P. and Donna R. Beshear

This book presents an integrated view of human disease. It serves as an essential link between the sciences of anatomy, physiology and biochemistry medical-surgical therapy and provides the nurse with an indepth understanding of the rationale for treatment modalities.

J. B. Lippincott, 1972 \$11.25 NURSING IN THE CORONARY CARE UNIT

LaVaughn Sharp, R.N., M.A. and Beatrice Rabin, R.N.

Content covers diagnostic measures, including interpretation of the oscilloscope and other electronic monitoring equipment, etiology, treatment, psychological support, and nursing intervention for all types of coronary artery disease.

J. B. Lippincott, 1970 \$8.25 10 SIGNS AND SYMPTOMS
Applied Pathological Physiology and Clinical Interpretation 5th Edition

10

Cyril M. MacBryde, M.C., F.A.C.P., Editor and Robert S. Blacklow, M.D., Associate Editor with 39 contributors

Revised to include new findings, this unique book offers a detailed analysis and interpre-tation of patients' most common com-plaints. Exceptionally useful in the development of intelligent observation and nursing assessment.

J. B. Lippincott, 1970

\$23.75

### **CLINICAL GERIATRICS**

Rossman

A comprehensive work covering the preventive, diagnostic and therapeutic aspects of disease processes in the aged. Includes psychologic, psychiatric and environmental considerations and discusses the vital role of the geriatric nurse on the therapeutic

J. B. Lippincott, 1971

\$25.25

### NURSING IN THE INTENSIVE RESPIRATORY CARE UNIT

Hannelore M. Sweetwood, R.N.

Here is the specific information needed to equip the nurse to function effectively in an intensive respiratory care unit. Much of the material, which has been tested in the actual teaching of nurses in this new specialty, is available in no other manual.

Flexible cover \$5.50 Springer, 1971

### 13 EMERGENCY-ROOM CARE 2nd Edition

Charles Eckert, M.D., with 26 contributors The tremendous increase in public demand for emergency-room services and facilities prompted important revisions in this basic reference for interns, residents, general surgeons, and nurses in dealing with emergency-room situations from severe accident cases to psychiatric crises.

Little, Brown, 1971 Flexible cover \$9.95

### **EMERGENCY-ROOM CARE** 2nd Edition

Little, Brown, 1971

Cloth \$14.75

### 15 INTERPRETATION OF DIAGNOSTIC TESTS

Jacques Wallach, M.D.

A most convenient source of facts for the nurse - tabulation, of normal values, laboratory findings on important diseases, and abnormal test results.

Little, Brown, 1970 Flexible cover \$7.95

### **POSTOPERATIVE CARDIAC** INTENSIVE CARE

M. V. Braimbridge, M.A., M.B., B. Chir., F.R.C.S. and Margaret Branthwaite, M.A., M.B., B.Chir., M.R.C.P., F.F.A.R.C.S.

The emphasis is on accurate assessment of the haemodynamic situation so that appro-priate measures can be taken to prevent cardiac deterioration. Each system is considered separately and preceded by a brief review of the physiological background. \$9.00 Blackwell, 1972

HAZARDS OF MEDICATION A Manual of Drug Interactions, Incompatibilities, Contraindications and Adverse Effects

Eric W. Martin, Ph.C., Ph.D. To help you avoid the hazards of medication

that today threatens patient safety, this new urgently-needed work features easy-to-use tables, on tinted paper. They give you quicl access to authoritative facts on drug inter actions and on drug interference with clinical laboratory tests. Succinct mono graphs discuss adverse drug reactions.

J. B. Lippincott, 1971 \$27.56

16

RESPIRATORY INTENSIVE CARE Beth Israel Hospital's Respiratory

Intensive Care Unit

This book is essential reading for nursing staff, physicians, graduate students, and in service education personnel involved in the Intensive Care Unit. After reviewing the an atomy and physiology of the respirator system, the text describes the diagnosis and management of respiratory disorders. Little, Brown, 1973

19 PATHOPHYSIOLOGY: **Altered Regulatory Mechanisms in** 

Disease Edward D. Frolich, Editor

with 52 Contributors

A unique, integrated approach to physiology and medicine that concentrates or conveying an understanding of disease: through comprehension of the underlying mechanisms. Throughout this medical tex a way of thinking is established which wil guide nursing personnel when confronter with puzzling clinical problems.

J. B. Lippincott, 1972 \$22.01 20 LEARNING ELECTROCARDIOGRAPHY

A Complete Course

Jules Constant, M.D. Learning Electrocardiography is a complete course in reading electrocardiograms. It is the only textbook that uses a stimulating question-and-answer format which disting uishes between basic and esoteric material \$23.50 Little, Brown

21 INTRODUCTION TO NURSING Third Edition

May Spencer, S.R.N., S.C.M. and Katherine M. Tait, S.R.N., S.C.M.

The authors have put their enthusiasm and wide experience into the second edition and brought it up-to-date with modern trends. I is a complete textbook for the student nurse and would be a valuable asset to the newly qualified clinical teacher. Blackwell, 1973

### **MATERNAL CHILD NURSING**

22 MATERNITY NURSING **Twelfth Edition** 

Elise Fitzpatrick, R.N., M.A. Sharon R. Reeder, R.N., M.S. and Luigi Mastroianni, Jr., M.D., F.A.C.S., F.A.C.O.G. This family-focused book is directed toward the total health and well-being of the mothe and infant. Comprehensive maternity nurs ing at its best. The importance of psycho social factors is reflected in the authors' de cision to integrate psychological principle: throughout the text.

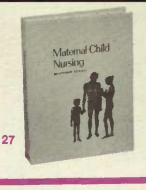
J. B. Lippincott, 1971 23 NURSING CARE OF CHILDREN

**Eighth Edition** Florence G. Blake, R.N., M.A. F. Howell Wright, M.D. and

Eugenia H. Waechter, R.N., Ph.D.
Text is organized according to age groups









from infancy to adolescence. Reflecting recent progress in all areas of care; newer approaches to treatment and care of orthopaedic conditions; special problems of the child with long term or terminal illness; new medical entities and associated nursing therapies. \$10.50

J. B. Lippincott, 1970

24 EMOTIONAL CARE OF HOSPITALIZED CHILDREN

An Environmental Approach Madeline Petrillo, R.N., M.Ed. and Sirgay Sanger, M.D.

This text is an outgrowth of the dedicated effort by a group of experienced clinicians to reduce the trauma in children, as well as parents, brought about by illnesses requiring hospitalization. Preventive approaches to minimizing trauma are supported by an analysis of actual clinical situations.

\$8.00 J. B. Lippincott, 1970

25 HELPING THE BATTERED CHILD AND HIS FAMILY

C. H. Kempe and R. E. Helfer Excellent background reading for all health personnel who may be confronted with the unfortunate "battered child" syndrome. This book covers the psychodynamics of abusive parents, and discusses desirable methods

and settings for optimal help. J. B. Lippincott, 1971

26 THE BATTERED CHILD IN CANADA Mary Van Stolk
The Battered Child in Canada approaches the problem of child abuse from a very realistic and practical point of view. This book contains both an in-depth survey of the present state of knowledge and some very worthwhile suggestions and applications made from the personal experiences of the author. The reader will better understand the serious plight of these children as well as the desperate need of their parents.

McClelland Stewart, 1972 Flexible cover \$3.95 MATERNAL-CHILD NURSING Violet Broadribb, R.N., M.S. and

Charlotte Corliss, R.N., M.Ed.

family-centered text, developed by the authors for combined maternal-child nursing courses wherein students are being prepared to give direct care to mothers and Flexible cover children. abt. \$6.25

J. B. Lippincott, 1973 28 FOUNDATIONS OF PEDIATRIC NURSING

Second Edition

Violet Broadribb, R.N., M.S.

The author, an experienced nurse clinician, has broadened and enriched the second edition to reflect new nursing concepts stemming from recent findings in child psychology as well as advances in pediatric medicine and surgery. New or expanded material includes psychosocial development, genetic factors, the child as member of a family unit, care of the newborn in the intensive care unit, pediatric pharmacology
J. B. Lippincott, 1973 \$7.95

### PHARMACOLOGY - DRUG **THERAPY**

29 DRUGS IN CURRENT USE AND NEW **DRUGS 1973** 

Walter Modell, M.D.

The 1973 edition of this annual standby for the health professions is a further improvement over the three widely hailed previous editions. The section on F.D.A. requirements for new drugs — which follows the familiar but always scrupulously updated data on older drugs - has now been considerably streamlined to make it more precisely applicable to the needs of health personnel. Flexible cover \$4.50

BONUS OFFER WITH ORDERS OF \$25.00 OR MORE

### PHARMACOLOGY - DRUG THERAPY

30 PHARMACOLOGY AND DRUG THERAPY IN NURSING

Morton J. Rodman, M.S., Ph.D. and Dorothy W. Smith, R.N., M.S., Ed.D.

This text's pharmacodynamic approach provides the student with a true understanding of the nature of drug action and a sound rationale for nursing intervention. Covers sources, dosage, physiologic action, untoward effects, contraindications and implications for nursing action.
J. B. LippIncott, 1968

Included:

Nurses Gulde to Canadian Drug Legislation

\$10.75

David R. Kennedy, Ph.D.

This pamphlet outlines the history and application of the Food and Drugs Act and Regulations of Canada and the Narcotic Control Act and Regulations of Canada.

### PSYCHIATRIC NURSING -**MENTAL HEALTH**

31 EMOTIONAL MATURITY:
The Development and Dynamics of

Personality Third Edition

Leon J. Saul, M.D.

An outstanding text and source book on our present knowledge of man's psychological self. Virtually all aspects of personality and behavior, development, conflicts and deviations from normal drives and motives are discussed. \$13.25

J. B. Lippincott, 1971

32 DEVELOPING THE ART OF UNDERSTANDING A Guide for Nursing Students

Margaret Anne Johnson, R.N. Written to help nurses — through discussion

## BONUS OFFER WITH **ORDERS OF \$25.00** OR MORE

**Drugs in Current Use and New Drugs 1973** 

Walter Modell, M.D.

You will receive this valuable book, worth \$4.50, as a bonus at no extra charge if you order books with a total value of \$25.00 or more. This new 1973 edition has been considerably streamlined to make it more precisely applicable to the needs of health personnel. It is a completely up-dated version of the widely acclaimed previous editions. A valuable addition to your library.

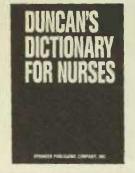
То	order,	circle	the	numbers	s of	the	books	you	wish	to
rec	eive O	N APP	ROV	AL. Add	your	nan	ne and	addr	ess	and
roti	urn to II	e								

; send II	ie the be	JUKS I H	ave circl	eu			
2	3	4	5	6	7	8	9
11	12	13	14	15	16	17	18
20	21	22	23	24	25	26	27
29	30	31	32	33	34	35	36
38	39	40	41	42	43	44	45
e			8				
ess					,		
n					Prov.		
	11 20 29 38	11 12 20 21 29 30 38 39	11 12 13 20 21 22 29 30 31 38 39 40	11 12 13 14 20 21 22 23 29 30 31 32 38 39 40 41	11 12 13 14 15 20 21 22 23 24 29 30 31 32 33 38 39 40 41 42	11 12 13 14 15 16 20 21 22 23 24 25 29 30 31 32 33 34 38 39 40 41 42 43	11 12 13 14 15 16 17 20 21 22 23 24 25 26 29 30 31 32 33 34 35 38 39 40 41 42 43 44

Charge my account, plus postage and handling

☐ Use my Chargex number .....

42



46



and illustration - resolve their own feelings about pain, disease, deformity, old age and

Springer, 1967

38

Flexible cover \$5.00

### 33 BEHAVIORAL CONCEPTS AND NURSING INTERVENTION Carolyn Carlson, R.N., M.S.

Identifies and examines in depth relevant concepts from the behavioral sciences and demonstrates their application to nursing. Provides valuable insight into the emotional problems of illness and hospitalization and their influence on the patient.

J. B. Lippincott, 1970 Flexible cover \$5.50

### BEHAVIORAL CONCEPTS AND NURSING INTERVENTION

J. B. Lippincott, 1970 Cloth \$7.75

THE PSYCHOLOGY OF DEATH

Robert Kastenbaum, Ph.D. and Ruth B. Aisenberg, Ph.D.

In-depth study of the historical, theoretical, and practical aspects of death. Authors Kastenbaum and Aisenberg proceed in the con-viction that death-related topics are relevant to all areas of human endeavour and that we may have more control over the factors that determine death than we realize.

Springer, 1972 \$11.95

36 ON BEING A WOMAN W. Gifford-Jones, M.D.

A completely revised edition of the international bestseller with new sections on abortion and birth control.

McClelland & Stewart, 1973 \$7.95

### **TALKING WITH PATIENTS** Second Edition

3rian Bird, M.D.
The new 2nd edition continues its warm, common-sense approach to patient personalities and problems, covering the techniques of talking with both children and

adults. New chapters include such concerns as the alcoholic patient, the "psychosomatic" patient, the delirious patient, and the diverse problems of the surgical patient. J. B. Lippincott, June 1973 abt. \$10.50

### **NURSING MANAGEMENT AND** ADMINISTRATION

### 38 NURSING MANAGEMENT OF THE PATIENT WITH PAIN

Margo McCaffery, R.N., M.S.
This brilliantly researched text presents sociologic psychologic and physiologic concepts within a problem-solving framework. The patient is viewed as a total human being with a variety of physical, emotional and intellectual needs and experiences. To this end, the author clearly outlines nursing action based on the many facets of the patient.

J. B. Lippincott, 1972 Flexible cover \$5.25

### 39 NURSING MANAGEMENT FOR PATIENT CARE

Marjorie Beyers and Carole Phillips Presents theories and methods of management for nurses who are striving to implement effectively the knowledge and skills of patient care in a hospital system. Divided into three sections (1) general management theories (2) the nurse as a manager (3) case studies.

Little, Brown, 1971 Flexible cover \$5.50

Little, Brown, 1971

**NEW DIRECTIONS FOR NURSES** Bonnie Bullough, R.N., Ph.D. and

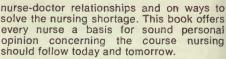
expansion of the nursing role, on change

40 NURSING MANAGEMENT FOR PATIENT CARE

Vern L. Bullough, Ph.D. A compilation of 40 selected readings on the



Cloth \$9.95



Springer, 1971

Flexible cover \$5.25

### 42 DUNCAN'S DICTIONARY FOR NURSES Helen A. Duncan, R.N., M.A.

Here are terms and definitions today's nurse needs to know, in a dictionary compiled especially for nurses. This compact dictionary is designed for on-the-job use by the busy nurse and ready reference by the student.

Springer, 1971

Flexible cover \$5.25

43 DUNCAN'S DICTIONARY FOR NURSES Springer, 1971 Cloth \$7.95

### 44 ADMINISTERING NURSING SERVICE Marie DiVincenti, R.N., Ed.D

In this uniquely informative book Miss Di-Vincenti gives a straightforward and bal-anced presentation of everyday approaches to the management of nursing services and demonstrates how management theories can be applied to the care of patients. Specific managerial tools such as budgeting, staffing, job organization and appraisal, and staft education programs, in addition to the important area of hospital and nursing service philosophies, are thoroughly treated. Little, Brown, 1972 \$10.50

### **NUTRITION - DIET THERAPY**

### BOWES AND CHURCH'S FOOD VALUES OF PORTIONS COMMONLY USED - Eleventh Edition

Charles Frederick Church, M.D., M.S. and Helen Nichols Church, B.S.

This handbook is invaluable in the practical study of comparative food values, the evaluation of diets from records of daily food intake, and in the planning and analysis of diets. Revised to reflect the latest nutritional findings, the manual contains calculations for thousands of foods, including many prepared and proprietary food products.

J. B. Lippincott, 1970 Flexible cover \$5.75

### 46 NUTRITION IN NURSING Linnea Anderson, M.P.H.

Marjorie V. Dibble, M.S., Helen S. Mitchell, Ph.D., Sc.D. and Hendrika J. Runbergen, M.S.

Normal nutrition, including such current con-cerns as ethnic and sociologic food patterns, consumerism, the ecology of food covering organic and macrobiotics growth and development and application of nutrition to critical periods of life, are covered in the first half of the text. The second half deals with clinical nutrition for many conditions of illness.

J. B. Lippincott, 1972

\$8.00



### **BUSINESS REPLY MAIL**

No postage stamp necessary if mailed in Canada. ostage will be paid by

I. B. LIPPINCOTT COMPANY OF CANADA LTD. '5 HORNER AVE.

ORONTO, ONTARIO

18Z 4X7





# All in the day's work . . .

An occupational health nurse in a large department store in Toronto shares some highlights of her work.

Liv-Ellen Lockeberg

As I got off the elevator on Eaton's fashion floor, I could see the brightly lit red cross over a passageway at the far end of the store. It was here, past some extra mannequins, that I found the door marked "Medical Services."

The unit's institutional green walls are brightened by a rack full of colourful travel brochures. The one "waiting room" chair has just been vacated. Two desks are face-to-face, full of "handouts," pink message sheets, and sundry forms. A young woman is at one of the telephones.

Mildred McCulley, the head nurse, is usually at her desk beyond the half-closed door of an office barely large enough for an extra chair, but ideal for confidential talk. A hammered copper blue jay hangs on the wall, and behind the door a large anti-smoking poster reminds her to give it up.

Ms. McCulley has engaged one of her spare nurses for the day, so she's free to show me around and explain now the T. Eaton Company of Canada, Limited, cares for its employees.

The cloak room that doubles for the nurses' rest room and repository for extra or unused equipment is beyond the treatment room. Here, at 9:45 A.M., a young man gets a glass of water to nelp him take some white powder in the spoon he's holding. The friendly panter between him and Cheryl Parker, the third staff nurse, is in keeping with

the informality of the medical center.

Young as he is, Fred is a problem drinker. He has spent three weeks as a patient at 8 May Street, a clinic run by the Addiction Research Foundation. Eaton's is one of 10 large Toronto firms that participates in the Foundation's program for alcoholics. Now Fred has to continue his treatment at work; the treatment includes taking regular doses of antabuse — the white powder on the spoon.

"We are proud of our association with the May Street clinic," said Ms. McCulley. She told me that two of Eaton's managers go to the clinic every Tuesday to learn how to recognize an alcoholic and how to confront him with his problem and the need for treatment. "The method we use in dealing with this illness — and it is treated as an illness - is called constructive coercion. If Fred is absent from work for an extended period, he will receive full sick pay benefits and his job will be held for him, providing he is cooperating with the clinic. In our experience, sobriety is two dry years," she added.

Moments later, a top executive enters the examining room. He has been too busy for his scheduled annual checkup, and the center has had to fit him in this morning before he goes

away again. Later, a comparison of his electrocardiogram tracings strongly suggests that a condition suspected more than a year ago has indeed developed and is progressing.

A physical examination at Eaton's is more than a blood pressure-heart affair; it encompasses eyes, teeth, condition of spine and feet, blood chemistry, urinalysis, and many other tests that seem warranted. If a condition requires attention or correction, the employee or applicant is referred to the family physician. However, for diabetic employees who require regular blood and urine analyses, samples are obtained at the store and sent to the lab to save time for both the employee and the company.

The doctor's office, a switchboard, a seven-bed hospital, and a washroom complete the unit that serves the 8,000 persons who work at Eaton's Queen Street Complex.

### Horses were important

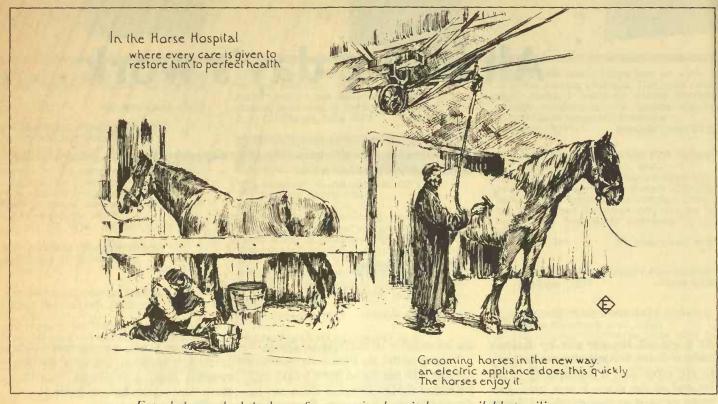
Eaton's is a "people place," according to Ms. McCulley. But there was a time when horses and their welfare were important, too.

When Timothy Eaton began his dry goods store in 1869, he used vans drawn by horses to deliver his merchandise. These horses received good care. All had stalls of their own and were housed in stables adjacent to the

The author is an assistant editor of *The Canadian Nurse*, *Ottawa*.

THE CANADIAN NURSE 33

**UNE 1973** 



Eaton's horses had the best of care, even a hospital was available to ailing ones.

store in downtown Toronto. The budget store still has a broad band of cement as part of its third floor, the site of the old stables.

An entry in Eaton's public relations pamphlet of 1908 states: "... 246 horses and 127 wagons are required. The horses are cleaned daily by 5 fast power machines in 1½ hours. These horses consume each day 120 bushels of crushed oats and 1\frac{1}{2} tons of hay. The horseshoeing is done on the premises. The stalls and floors are all scrubbed and disinfected each morning, and apart from the stables proper is the hospital ward containing 13 box stalls, where a horse showing the least sign of indisposition is quickly placed and promptly attended to. A perfect system of ventilation has been installed in the stables, so that fresh air is constantly pumped in and the used air is forced out. So well cared for are all the horses that the percentage of sick or ailing is very small."

The welfare of Eaton's horses was again mentioned in 1925, when an epidemic of pink eye and purpura appeared: "A large tent covered part of what is now the College Street parking

lot and contained about 150 head of sick horses — as they took sick upstairs in the Hayter Street stables, they were put down in the tent."

### First store nurse

The first reference to the welfare of people is in Eaton's 1907 public relations pamphlet: "On the second floor may be found a large comfortable waiting and writing, also reading room, where one is ever welcome to rest, or meet and chat with friends. In connection with this Waiting Room is a Public Nursery and Emergency Hospital, one of our staff always in attendance to care for restless 'bairnies,' or render aid in sudden illness and accidents. Doctors are on call for emergency summonses, and everything is done for the welfare of all in the store."

The first store nurse was employed in Winnipeg in 1910. Ives King studied nursing at the Winnipeg General Hospital and stayed on as company nurse at Eaton's until 1939.

Early in her career she was delegated to tour other department stores on this continent, notably in Boston, New York, and Philadelphia. When visited

in The Vancouver General Hospital just a month before her death in November 1956, Ms. King said, "I was made welcome on the trip and remember well viewing the Lord and Taylor New York store hospital. They had a well-equipped operating room. Macy's had the best set-up, but I went back to Winnipeg satisfied that my store, Eaton's, did not lag behind any other department store."

In 1918, Eaton's public relations pamphlet "A Few Facts About the Store" documents the company's concern for its employees:

"The Welfare Department [staff relations department], with over 350 welfare secretaries\* and four visiting nurses looks after the physical wellbeing of employees. In connection with

this department, there are two hospitals in care of trained nurses, for the benefit of customers and employees, where

<sup>\*</sup> Eaton Welfare Secretaries were "competent women staff members whose duty it was to see that no female employee was ever without someone she knew and trusted to turn to in times of trouble, whatever the its source."

rest and quiet may be obtained and first aid rendered when necessary.

"A dentist is in attendance every morning in a well-equipped dental office, where examinations are made, advice given, x-ray work done, and temporary relief afforded where necessary."

### Forty nurses now

Currently, there are some 40 occupational health nurses located in Eaton's 13 medical centers from coast to coast. As in other industries, their chief role is to keep the staff healthy and working, assisting with on-the-job rehabilitation after any lengthy illness.

Ms. McCulley, a graduate of St. Michael's Hospital school of nursing, has been with Eaton's medical services since 1955. During her 18 years with the company, the emphasis has swung from treatment and/or home visiting to preventive programs.

Anne Callow, a public health nurse originally from Kent in England, and Cheryl Parker, from Prince Edward Island, formerly of the Toronto City health department, are the two other full-time nurses on staff at the Queen Street store. In addition, there is a full-time nurse at each of Eaton's four other units in the city.

"To cover all areas in Toronto at all times, we have to employ a large occasional staff," said Ms. McCulley. "For instance, there were 21 on our payroll last week. They are public health nurses, staff nurses, and registered nursing assistants. All seem to like working with us, as most have been on our full-time staff in the past.

"When hiring new nurses, we look beyond their academic achievements and past experience, as personality, an ability to establish rapport and to think quickly and independently in an emergency are important in occupational nursing."

### Prescreening

The most time-consuming, yet important, part of the health program at Eaton's is the screening of applicants for work — about 70 to 80 per week at peak hiring times of the year. Particular note is made of existing health problems of applicants.

Screenings take into account the kind of work being sought. In the case of truck drivers and delivery men, a strong back is essential. For elevator operators, it becomes a question of varicose veins as well. For everyone, eyes, ears, and teeth are important. Oral problems are more common than one would expect, according to Ms. McCulley, and they can be corrected.

Prescreening is intended to cut down on the use of hospital insurance and on lost time. Both can be costly if newly-hired personnel immediately book themselves for elective surgery.

Applicants are not denied employment because of apparent defects. But, if a person is hired, he must take steps to correct a problem. For instance, poor teeth must be attended to within the prescribed interval of 90 days. Nor are conditions, such as epilepsy or diabetes, deterrents to employment at Eaton's — although the applicant with epilepsy will not be expected to run an elevator, drive a truck, or lift heavy weights.

The medical office is always ready with emergency treatment and preventive therapy; its motto is "prevention and control."

### Ongoing program

"The paper work is fantastic," said Ms. McCulley. "We started a new key punch record system six months ago, from coast to coast. The first reject report is on my desk now." The data center for the company is in Toronto. "We have employee files, employee cards, forms and referral slips, to mention a few items. We are part of the personnel department, and that eases some of the load."

The medical services unit is open during store hours, and everyone comes to the clinic, making it unnecessary for the nurses to function outside it. Judging from the traffic, there would be no time to function otherwise. Between 75 and 80 people come each day, most of them employees.

Eaton's holds periodic blood donor clinics. The x-ray program for tuber-culosis is about to be discontinued. Stress now is on educational programs. Films on self-examination of the breast for early signs of cancer have been

shown in the staff training rooms during lunch time. Contraceptives are the subject of the current program. The next project will be venereal disease control.

As Eaton's sick benefit plan does not cover dental, obstetric or elective surgery, wide-scale programs in these areas are not offered. Here again, the medical officer lays the stress on prevention of problems, rather than on corrective treatment.

However, several long-term employees—some have had 50 years of service—have retired due to illness. Ms. McCulley mentioned one employee in the lingerie department, who has worked for 30 years. She is suffering from arthritis that has been progressing over the years. "How she can even hold a pencil is beyond my comprehension," said Ms. McCulley. "We have recommended that she be on sickness income. This will carry her for a year. Then she can go on disability pension to take her to her normal retirement age, even though that is nearly two years away."

There are many opportunities for counseling, another major function of the nurse at Eaton's. While I was talking to Ms. McCulley, a saleswoman arrived in the clinic to soak her thumb in saline — a hangnail was bothering her. This gives her a chance to talk about some of her problems, glad of a listener and someone to show concern for her. She lives alone and a long way from work. "It's probably just too much bother to do the soaking job at home, where she has no one to talk to," said Ms. McCulley. "She doesn't abuse the privilege of coming to the medical unit, as her card shows that it's several months since her last visit.'

Eaton's is a miniature world, with its cross-section of nationalities; thus, communication can be a problem. When Marika, who works in the kitchens, got the tine of a fork in her finger, she came to the medical center only when it became infected. On being told she had to be absent until her finger healed, she became upset and agitated. "Someone who spoke Ukrainian had to be found to help us," said Ms. McCulley. "The interpreter was able to assure her she was not being fired and that she would continue to

THE CANADIAN NURSE 35



get her wages while at home. Marika's reluctance to report her infection stemmed from her need to work, as her husband's heart condition kept him at home."

Anything can happen!

Accidents cannot be ignored, and they add the unexpected to a day that is already packed with activity. Stretchers and wheelchairs are located on each floor of the store, and employees have been taught how to use them and the procedures to follow in emergencies.

One customer, a poor, elderly man wearing slippers but no socks, collapsed in the budget store on a cold January day. He was brought to the unit by

stretcher. He needed only nitroglycerin to recover sufficiently from his angina attack to go home.

Later, a young man who had fallen down the escalator, was brought in by stretcher. He was so drunk that he had to be left on the stretcher until the police, called by the security officer, came to take him to hospital for observation. The escalator company reports all incidents to the department of labor. If a person falls on stairs, there is no company liability if the tread is in good condition.

Then there was the old man who had tumbled down the subway station escalator and who was brought to the medical center for first aid. Instead of resting after his ordeal, he insisted on going to eat in Eaton's dining room — that was why he had come downtown!

Should a customer cut himself, the nurses will apply a bandage, but will not give tetanus. As this is a referral unit, rather than a treating unit, he must go to his own doctor. "However, if a shopper asks us, we will administer glaucoma drops," added Ms. McCulley.

All visits are recorded, even when it's just "something for a headache." Customers are given the choice of aspirin, a "222," or a fizzy drink, and decide what they will have. The report will note that the remedy was given "at client's own request."

Alligators and cuckoo clocks

"Even Santa Claus has had an accident," said Ms. McCulley. "We have two men in the carpenter shop who fill the role. One has to be reminded of his diet once in a while, as he has to fit his suit each Christmas. When our other 'Santa' caught his hand in a planing machine, it was touch and go. His buddies brought him to us, his squashed hand in a paper bag. Fortunately, he lost only two fingers.

"Far-out things happen, too, and many strange reports have gone to the Workmen's Compensation Board," Ms. McCulley said. "For instance, young Marnie in the pet shop was bitten by an alligator. The bite became infected; she needed antibiotics and was off work long enough to draw workmen's compensation. The report did not say that the alligator was barely six inches long!

"More recently, Jill, a saleslady in the gourmet shop on the ground floor, was knocked down by a cuckoo clock that fell off the wall, probably due to the vibrations of the underground trains. She had to go through the company's 'headache routine' and had x-rays taken of her skull. She suffered from persistent headaches for several weeks before she could return to work. Again, Workmen's Compensation was involved."

At three o'clock, just as I was getting ready to leave Ms. McCulley and her staff, Victor, from the carpenter shop, came to the medical center holding his wrist; a counter had fallen on it. A huge hematoma was forming. The doctor, on his way to a meeting, ordered ice and a pressure dressing to be applied. One of the nurses started the treatment.

It was all in the day's work . . . . 🗳

**IUNE 1973** 

# Delusions that trap nurses . . .

... into dead-end alleys away from growth, relevance, and impact on health care

### Catherine M. Norris

EVERYONE at some time fiction-alizes experience to maintain comfort and to satisfy needs for prestige and power. Some people, however, have to build a whole system in which activity is transformed into fiction to meet their security and comfort needs. In terms of psychopathological theory, such fictions which become fixed are called delusions and, therefore, sick. Another theory states that mental illness is a myth, and delusions are thereby normal. In examining nursing's delusional system, however, as I propose to do in this paper, the real goal is not to determine normality (goodness) or sickness (badness) but, rather, the functions served by the delusions and the goals the delusional system is supposed to achieve for the profession.

# DELUSION 1: Nurses are in general agreement about what nursing is

Nothing could be further from the truth than the above statement. If one asks nurses how they define nursing, the responses are so varied that it would be truly remarkable for nurses who take positions at one end of the range to have any communication with nurses at the other end. Some nurses think of

Formerly associate professor of nursing education at the University of Kansas Medical Center, Kansas City, Dr. Norris is now a part-time nursing clinician and consultant. A graduate of Massachusetts General Hospital School of Nursing, Boston, with her Ed.D. from Teachers College, Columbia University, New York, she has contributed many challenging articles to the nursing literature.

themselves as "professional friends"; some conceive of nurses as life-long scholars and champions of the health needs of man; some see themselves as assistants to the physician; some perceive their major role as managers of the therapeutic regimen. There are those who see themselves as, essentially, participants in a significant interpersonal relationship; some perceive themselves as providers of care and comfort, and still others view themselves as facilitators of patient goal achievement. Quite a few nurses don't give much thought to the question at all; they simply do what is requested to receive the best salary they can command.

Whatever the range of ideas about the nature of nursing — broad or narrow, comprehensive or fragmented, personal or impersonal — nurses at the operational level are free to implement their own concept as long as employers don't make explicit their own

definition translated into a program of care. Lack of specificity serves to reinforce the delusion.

What function is served by the delusion that all nurses agree about what nursing is? It may foster feelings of colleagueship and promote cohesiveness among those who call themselves nurses. It may reassure them that nursing has not changed greatly but is still an occupation that depends pretty much on practical knowledge and good old common sense. On the other hand, it may function as a cover for the fact that nurses do not know and cannot identify the theory base upon which they operate. They therefore overgeneralize, since any attempt to identify, specifically, the nature of nursing would expose their ignorance.

# DELUSION 2: Nurses care for and are concerned about patients

When nurses describe nursing they usually use such words as love, tenderness, sensitivity, care, acceptance, concern, empathy, comfort, and support to identify the major "gifts" that they provide for patients or to characterize the nurse-patient relationship. This has been part of the nursing platform for almost a century. It is also common knowledge that nurses have not been able to deliver this bounty in any consistent way to any sizable group of

THE CANADIAN NURSE 37

Copyright January 1973, The American Journal of Nursing Company. Reprinted from Nursing Outlook, January 1973.

**JUNE 1973** 

patients. And, if there is any group of people who do not feel cared for by nurses or other health professionals, it is the North American public — sick or well.

For a generation it has been the rare patient who sees a nurse for more than a few minutes a day. If he does see a nurse, he rarely learns her name; she may not know his, either, and the interpersonal interaction may sound more as if the nurse were a drug pusher than a lover. Yet, in the face of a hundred years of failure in this particular function, nurses still persist in saying they "care" for their patients. Nursing has never raised the critical question about whether it is possible to have warm feelings, to say nothing of concern, for the hundreds of patients a nurse is responsible for in the course of a week or two.

All nurses have their personal problems and stresses and today most nurses are married, which may further deplete the emotional energy available for the job. But even if all nurses had absolutely normal mental health, would it be humanly possible for them to be emotionally concerned about all of the twenty million people who are hospitalized every year, plus the millions of others who are seen in clinics and offices and homes? Is it a concept of practice that is deliverable? Is it even as realistic as the thesis that, when extracorporeal renal dialysis or open cardiac surgery is needed, priority should be given to those with the greatest potential for benefit?

The concept of payment for tenderness and concern or even for real encounter is an interesting one. There are nurses who find the idea repugnant and those who say this is an extra benefit — that human concern cannot be bought. Other nurses believe this is part of what nurses are paid for and they obsess endlessly about it, operationalizing it on paper and in practice. At this point in time, however, the idea is part of a delusional system about nursing practice.

What function does the delusion that all nurses care for and are concerned about their patients serve? Does it echo the teacher and thus represent the right thing to say? Does it mask guilt for not loving patients? Does it serve as an attempt to compensate patients for pain, unpleasant treatments, or discouraging diagnoses? Or does it camouflage the fact that nurses do not know how to describe nursing processes and the theory that guides their development and use?

### DELUSION 3: Knowledge prevents disease

Another major delusional system in nursing relates to the prevention of illness and promotion of health. Nurses believe, or act as though they believe, that knowledge prevents disease. All nurses "know" that the American people use health knowledge in determining their modes of living, meeting their basic needs, and in preventing illness.

But maintaining this belief requires one to dissociate, compartmentalize, or ignore the fact that cigarette smoking has not decreased; that saturated fats still constitute a great percentage of our diet; that millions of people eat hamburgers, hot dogs, and pop in preference to more nutritional foods. It requires us to ignore that automobiles must be in good mechanical shape and that people who drive under the influence of extreme anxiety, rage, drugs, or alcohol are taking their and other lives in their hands. It forces us to ignore the large numbers of chairsitting, TV-watching, button-pushing, nonactive persons who avoid healthpromoting activity.

It also means disregarding the pathologic effects of a century of patent medicines and pill popping, along with the more recent trends of tripping and mainlining. Clinically, we must ignore the 50 percent of all strokes that could have been prevented; the coronaries by the million that should not have happened, the accidents and traumas

by the hundred thousands, alcoholics by the million, terminal cancer by the hundred thousand, and millions of readmissions for diabetes, mental illness, and complications of aging.

All around and among us the message is clear: the North American people do not use the knowledge available to help determine their life-style, to meet their basic needs, or to promote their optimum health and well-being. Therefore, knowledge does not prevent disease in millions of cases. The strength of the delusion to the contrary becomes apparent in the resistance encountered when one asks how knowledge prevents disease or about the nature of the interactive dynamism between knowledge and change in life-style or habitual practices.

What function does this delusion perform for nurses? Does it prevent feelings of helplessness by making the job of changing the human condition seem easy and simple and therefore within the realm of nursing intervention and possibility? Does it function to cover nurses' ignorance and justify continuation of the act of exhortation which they know so well? Does it endorse the "all things to all people" concept of nursing? Or does it cover nurses' inability to identify valid theory that could guide them in promoting health and preventing disease?

### **DELUSION 4: Nurses significantly** influence patients' lives

In terms of cure, nurses in intensive care probably do influence patients' lives but they do this in the role of physician's technical assistant. When it comes to helping patients to cope with their illnesses or to establish new health goals or changed life styles, however — even in life-threatening circumstances — the average patient doesn't see a nurse and does not expect this kind of assistance.

This is not to deny that a few nurses in a few rare situations greatly influence patients' lives. But, even though people can be influenced profoundly during

periods of crisis, it is probably irrational to think that in a three- to fiveday hospital stay nurses can greatly influence the life of the average patient. The continuity, kind of relationship, and problem-solving processes that are necessary to engender real behavioral change are rarely possible in clinics or homes, either.

Nurses' resistance to taking stands, debating issues, assuming new roles, and being more accountable prevents them from making any real impact on patients' lives; another deterrent influence is their reluctance to grapple with the tremendous complexity involved in influencing the human condition. If nurses greatly influenced patients' lives, there would surely be a great store of commonly known data to support the claim.

Why, in the absence of data and general public consensus, then, do nurses protest their influence and importance to patients? All people need to feel important, so this might be one function of the delusion. Before the advent of chemotherapy, surgery, and roentgenotherapy, nurses were as important as doctors, so the delusion may be an attempt to deny the realities of the present. As pointed out earlier, one way to cope with frustration is to overgeneralize. When nurses cannot identify what the influential "something" is that they have to offer, when they cannot refer confidently to a body of theory or science, they can resort to telescoping the whole process of professional practice into a vague or imprecise outcome of practice. Is this the function of this delusion?

### DELUSION 5: Professional nursing skills have market value

Some students of the nursing scene are asking if professional nursing skills can be utilized or professional nursing practiced in hospitals or nursing homes. At least one nurse has data that some nurses who have no opportunity to practice professionally leave nursing.1,2,3 Other nurses point out that **JUNE 1973** 

employing agencies do not define differences in technical and professional nursing and that only a few agencies pay a small differential to professional nurses.4 Practical nurses are increasingly functioning at team leader and head nurse levels.

In addition, the preventive component of the health maintenance organization concept — one in which nurses might be expected to figure significantly — is slow in developing. Neither the employing agencies nor the public are demanding that nurses teach, provide sociopsychiatric support, or help people to develop more healthful life-styles. Services of this nature represent the essence of professional nursing — but only in rare situations are they given enough recognition and priority to be allowed or supported. In fact, professional nursing skills might be likened to luxury items for patients after technical nursing has provided what they "really" need.

If the majority of professional nurses did not marry and leave the field at or within one year of graduation, the hue and cry in relation to this role deprivation might be very loud. The ones who remain in nursing, however, tend to adopt bureaucratic role conceptions and to function on a technical level. If they became activists instead, they might define the problem and dispel this delusion.

The function of this delusion is that it justifies present patterns and enhances prestige: that is, while professional nursing skills may not be useful now, we are really looking forward to the health care system of the future when nurses with these skills will be prepared and ready to step into important roles in the system.

This delusion may also dispel nurses' feelings of helplessness and alienation brought about by (1) their loss of importance in patient welfare as a result of technological advances in medicine; and (2) their loss of function as a result of their having handed over much of the physical care of patients to technicians and ancillary personnel. This delusion may also mask nurses' inability to interpret in theory or demonstrate in practice the need for or benefits of professional nursing care.

### **DELUSION 6: Nursing is patient** centered

"But," counter Dickoff and James, "patient-centered nursing may be just another pipe dream following the discarded practice of disease-centered nursing."5 When nurses integrate the "patient-centered" delusion into the system, they overlook the fact that the needs of physicians, the demands of the system or bureaucracy, the timeconsuming routines, the endless secretarial duties, the supervision of countless technical and ancillary personnel, as well as the urgent needs of many patients, all take precedence over consideration of and concern for individual patients.

If patient-centered means uniqueness of each patient, how can nurses explain the manuals, procedure books, and standing orders which communicate that all patients are processed or treated in the same way? (But then delusions do not have to be explained logically.) If patient-centered means that ill people need special care or consideration, how do nurses deal with expressions of special need like anger, complaints, weeping, refusal to cooperate, demands for special attention, and feelings of hopelessness and helplessness?

Do nurses express joy at being able to respond helpfully to these unique personal expressions of need? Is time allowed and planned for patientcentered care, or is it the routines and tasks that are planned and emphasized? Have nurses asked if all patients need individualized care in all areas of behavior or whether some patients either cope well or have pre-existing ways of getting help? But above and beyond the questions is the fact that nurses are so seldom visible at the bedside and so few patients know they have seen an "R.N." during their illness. It cannot help but follow that if nurses are not there, they cannot give patient-centered care.

The delusion that nursing is patientcentered — rather than hospital-centered, work-centered, or doctor-centered - serves to make the nurse feel virtuous. It gives the impression that nurses respond to a patient's needs or that the patient might even define this need so that the nurses can respond. Another function of this delusion may be that it permits nurses to bypass working out the complex theories that could guide practice and the development of new knowledge about patients and thus produce more predictable outcomes. It also allows nurses to practice without working out carefully the processes through which the work of a profession is accomplished. The processes of history taking and of nursing assessment, diagnosis, and intervention are still in primitive stages of development after more than a decade of work

### Common Sense — Or Valid Theory?

Nurses also delude themselves into thinking that they have considerable autonomy, independence, and freedom to control their own destiny. They believe that hospitals are set up to offer the best in health care and that they do, in fact, offer good care. They believe that patients follow physicians' and nurses' advice and derive the most benefit out of the care they receive. They believe that impossible tasks can be done in impossibly short periods of time, such as resolution of developmental tasks and conflicts, improvement in problem-solving skills, increase in self-esteem, and so on.

All these fictions organized as a system proclaim that nursing is a vital, socially significant, fairly independent, autonomous process that offers individualized care and concern to patients who are ill and promotes health and prevents disease among both the ailing and the hale. Most nurses can recognize the similarity of this statement to definitions of nursing they wrote as students for a foundations of nursing

course. They pulled these definitions out of their heads or paraphrased some leader in nursing to further sustain the delusional system. But what else can or could they do, in the absence of nursing theory or other theories, of bodies of knowledge, or of methodologies of synthesis to use in making knowledge relevant and useful in the solution of nursing problems?

Some who could not admit, in the middle of the knowledge explosion, that they were nursing by guess and by gosh took the anti-intellectual route and went to the defense of an action-oriented, good common sense approach to nursing. The "good common sense" nurses are comfortable doing what is expedient. But those who believe they have a responsibility to make knowledge relevant to patients' health problems and to discover knowledge that will improve care feel helpless without the support of a theoretical frame of reference.

Such a frame of reference would provide a guide for developing systems for delivery of nursing care, for developing nursing education programs, for teaching nursing, and for interpreting nursing to all comers. Is it too late to work through our system of fantasies? Is it too painful to tolerate the stress of uncertainty and the complexities of formulating and testing theories of potential use to nursing?

### References

- Kramer, Marlene. Role conception of baccalaureate nurses and success in hospital nursing. *Nurs. Res.* 19:428-439, Sept.-Oct. 1970.
- 2. —, and Baker, Constance. The exodus: can we prevent it? *J. Nurs. Admin.* 1:15-30, May-June 1971.
- 3. Kramer, Marlene, et al. Self-actualization and role adaptation of baccalaureate degree nurses. *Nurs. Res.* 21:111-123, Mar.-Apr. 1972.
- Sheahan, Sister Dorothy. The game of the name: nurse professional and nurse technician. Nurs. Outlook 20:440-444, July 1972.
- 5. Dickoff, James, and James, Patricia.

Beliefs and values: cases for curriculum design. *Nurs. Res.* 19:415-427, Sept.-Oct. 1970.

# dates

### June 11-15, August 27-31, 1973 February 18-22, 1974

One week course for nurses involved in prevention, control, and management of tuberculosis. The course, to be held in Ottawa, will be sponsored jointly by the University of Ottawa School of Nursing and the Canadian Tuberculosis and Respiratory Disease Association. For further information, write to: Ms. Lorette Morel, CTRDA, 345 O'Connor Street, Ottawa, Ontario.

### June 13-14, 1973

National League for Nursing, continuing education workshop on the associate degree practitioner and nursing service needs, U. of Maine at Augusta. Fee: \$40 for NLN members; \$80 for nonmembers. For further information, write to: Convention Services, NLN, 10 Columbus Circle, New York, N.Y. 10019, U.S.A.

### June 15-16, 1973

Edmonton General Hospital class of 1963, 10th year reunion. Letters to classmates would be welcome, if you are unable to attend. For further information, write to: Doreen Moisey, Box 6, Site 13, R.R. #1, Sherwood Park, Alberta T8A 3K1.

### June 17-23, 1973

18th International Hospital Congress, 6th National Convention, and 30th Assembly, Canadian Hospital Association, Place Bonaventure, Montreal, Quebec.

### June 22-24, 1973

Regina Grey Nuns' Hospital School of Nursing is closing after 65 years in operation. Final graduation will be held June 24 and a "last homecoming reunion" is planned for June 22-24. Graduates wishing to obtain transcripts after the school closes may write to the Saskatchewan Registered Nurses' Association office in Regina. For further information, write to: Ms. C. O'Shaughnessy, Director, School of Nursing, Regina Grey Nuns' Hospital, Regina, Saskatchewan.

### June 23-27, 1973

Canadian Pediatric Society, annual meeting, Quebec City. For further information, write to: Beryl Rosebush, Dept. of Pediatrics, Centre Hospitalier Universitaire, U. of Sherbrooke, Sherbrooke, Quebec.

### June 25-27, 1973

Emergency Nurses' Association of Ontario three-day conference, Royal York Hotel, Toronto, Ontario. Enquiries may be directed to: Ms. A.M. Harris. 30 Ellen Street, Brampton, Ontario.

### June 29-July 1, 1973

Homecoming Weekend, Nova Scotia Hospital Alumni Association. For further information, write to: Ms. Brenda Sinclair, 138 Pleasant Street, Dartmouth, Nova Scotia.

### BRITISH COLUMBIA INSTITUTE OF **TECHNOLOGY**

invites applications for the following positions:

### INSTRUCTOR MENTAL HEALTH NURSING

For community oriented mental health nursing courses offered at B.C.I.T.

Qualifications: A Baccalaurate degree, some experience in psychiatric nursing and eligible for RN licensure in British Columbia.

Salaries will be commensurate with the applicant's overall qualifications within established scales which currently range from a minimum of \$817 to a maximum of \$1370 per month.

These are Civil Service positions within the Division of Post Secondary Education, Technical-Vocational Branch. Salary will be commensurate with applicant's qualifications.

### Please apply:

The Personnel Office B.C. Institute of Technology 3700 Willingdon Avenue Burnaby 2, B.C.

### June 24-27, 1973

Canadian Tuberculosis and Respiratory Disease Association, 73rd annual meeting; Canadian Thoracic Society, 15th annual meeting and 10th annual nurses' institute, Palliser Inn, Calgary, Alberta. For further information, write to: Mr. H.E. Drouin, Executive Secretary, CTRDA, 345 O'Connor St., Ottawa.

### July 16-August 3, 1973

Workshop on "Psychological Concepts of Human Sexuality as they Influence Family Planning and Sex Education," Loyola of Montreal, Summer School. Fee: \$100. For further information, write to: Ms. G. Lennox, Program Coordinator for Health Education, Loyola Evening Division, 7270 Sherbrooke St., W., Montreal 262, P.Q.

### August 19-20, 1973

American Academy of Medical Administrators, 16th annual convocation, luncheon and reception, Continental Plaza Hotel, Chicago, Illinois, U.S.A.

### August 20-23, 1973

American Health Congress, McCormick Place, Chicago, Illinois. For further information and registration forms, write to: American Health Congress. 840 N. Lake Shore Drive, Chicago, III. 60611, U.S.A.

### September 10-11, 1973

American Cancer Society, national conference on cancer nursing, Palmer House, Chicago, Illinois. Theme: "Cancer Nursing: Precepts, Principles and Practice." For further information. write to: Virginia Barckley, R.N., National conference on Cancer Nursing, 219 East 42nd St., New York, N.Y. 10017.

### September 20-22, 1973

Ontario Occupational Health Nurses' Association, second annual convention, Holiday Inn, London, Ontario. For further information, write to: Ms. P. Read, Head Nurse, Health Service Dept.. Victoria Hospital, London, Ontario.

# in a capsule

### Child safety week --- for everyone

In Canada, more children under 15 years of age die from accidents than from the next four causes of child death combined. Each year some 2,000 children die from accidents, and hundreds

of thousands are injured.

For this reason, the Canada Safety Council sponsored National Child Safety Week May 1 to 7 — a national campaign "to focus the attention of all Canadians on this tragic record of death and injury to children caused by accidents.

In its Guide For Child Safety, the Council gives advice on preventing accidents that occur from suffocation, falls, burns, cuts, toys, electricity,

poisons, drowning, fire and explosion, traffic, machinery, and firearms. "A positive attitude toward safety instilled in children, starting with the very young, will equip them to cope with hazards all their lives," it points out.

The Safety Council notes that the most dangerous ages of child accidents are two and three; these occur most often in late afternoon and evening.

Here is some practical advice the

Council gives:

 Adults should see that children are taught and understand the rules of traffic and pedestrian safety before they are allowed out to play and allowed to ride bicycles on public roads.

• Children should be secured in ap-

proved child restraint devices or, if they are old enough, wear seat belts in

• Children should wear clothes with retroreflective tape attached so that motorists can see them after dark.

• Never discard appliances, such as abandoned refrigerators and freezers, without first removing the doors.

• Teach youngsters to swim at a very early age. Small children must be watched constantly when they are near any body of water, no matter how small or shallow.

If you would like more information on child safety, write to the Canada Safety Council, 30 The Driveway, Ottawa K2P 1C9,

### Photo checklist

If you are ever faced with the job of sending photographs to an editor to illustrate news writeups, the following pointers on correct photo procedure will help you and the editor — and perhaps mean the difference between your photograph being used or rejected. This list is adapted from the February 1973 issue of Volunteer, published by the Ontario Hospital Association.

• Hire a good photographer, one who will use imagination in composing the

picture.

 Do not send photos of a group of people all staring eagerly at the camera.

• Do not send matte prints. A glossy finish gives better results.

• Caption the photo, even though a press release is sent with it. Identify everyone in the photo by first and last

 Make sure captions can be easily removed from the photo. An easy way to do this is to perforate the caption sheet, making it possible to tear it neatly from the photo.

 Never use paper clips or staples on photos. Use cardboard stiffeners when

sending them.

• Do not advise the editor that photos are available on request. Always send photos with the news they are intended to illustrate.

 Do not request that photos be returned unless there is a special circumstance in which the editor has asked you for photos.

 Indicate the source on the back of all photos, even when captions are attached.



# names

Nancy Garrett is currently on assignment with the Canadian International Development Agency. She spent one month planning her itinerary to make the best use of her eight-week visit to 11 countries of French-speaking Africa. The purpose of her visits is to evaluate family planning programs in these countries and, later, report on their need for continued assistance from Canadians and/or their readiness to assume responsibility for their own programs.

Since her appointment with the Canadian Nurses Association as research officer, Ms. Garrett has "zeroed in" on family planning, has been a member of several expert committees, and has written articles in both English and French for The Canadian Nurse

and L'infirmière canadienne.



Nancy Garrett



David Sparkes

David G. Sparkes was appointed employment relations officer of the Association of Registered Nurses of Newfoundland, March, 1973.

Mr. Sparkes, a graduate of the Canadian Hospital Programme in Hospital Organization and Management, has held senior administrative positions in hospitals in Grand Falls and St. John's, Newfoundland. He was a founding member of the Canadian College of Health Service Executives.

Mr. Sparkes assists nurses with matters pertaining to their employment, particularly the requirements and application of the collective agreement. He will also play a major role in liaison with nurses to formulate future proposals and the negotiating of subsequent collective agreements in Newfoundland.

Margaret Wakeling of Regina has been appointed a consumer representative on the council of the Saskatchewan Registered Nurses' Association, with voting privileges to begin in June, 1974.

She was named by the Saskatchewan branch of the Consumers Association of Canada at the request of the SRNA.

Ms. Wakeling is chairman of the health services committee, provincial branch of the CAC

She is also vice-president of the YWCA, president of the Lawyers' Wives Association, and secretary of the Norman Mackenzie Art Gallery Society.

Kathleen G. DeMarsh (R.N., Saskatoon City H., Saskatoon, Sask.; dipl. teaching and superv. and B.A., U. of Toronto; M.Sc.N., U. of Western Ontario, London) has been appointed vice-president, nursing, for the new Health Sciences Centre in Winnipeg, Manitoba. She has special responsibility for pediatric care.



On February 1, 1973, the Winnipeg General Hospital, the Children's Hospital of Winnipeg, and the Manitoba Rehabilitation Hospital and D.A. Stewart Centre merged to become

the Health Sciences Centre. Ms. De Marsh had been with the Winnipeg General Hospital since 1967 as director of nursing and assistant executive director.

A native of Tisdale, Saskatchewan, Ms. DeMarsh has held appointments as night supervisor at Saskatoon City Hospital and director of nursing education at The Brantford General Hospital in Brantford, Ontario. From 1946 to 1951, she served the Canadian Red Cross Society in several capacities, including director of Red Cross outpost services. As assistant national director of nursing services, she served for six months with the International Red Cross in Austria and the Nether-

From 1970 to 1972, Ms. De Marsh was first vice-president of the Canadian Nurses' Association. She has also been a Canadian Nurses' Foundation scholar. She has served as chairman of the nursing services committee of the Canadian Council on Hospital Accreditation and has continued to be a nurse surveyor for the CCHA.

Kathleen DeMarsh is a member of the research committee of the Manitoba Association of Registered Nurses and

is the MARN representative on the Manitoba Hospital Association Accreditation steering committee. She is on the board of the newly established Manitoba Institute of the Family. Early in 1973, the deputy minister of the department of national health and welfare appointed her to the national health grant subcommittee on health care delivery.

Ella MacLeod, president of the Association of Nurses of Prince Edward Island, has been appointed to the Prince Edward Island Civil Service Commission, its first nurse member.

Ms. MacLeod (R.N., St. John General Hospital School of Nursing; Dipl. Teaching and Superv., U. of Toronto; B.N., McGill U.; M.Sc., Boston U.) has taught at the St. John General Hospital School of Nursing, has been a consultant with the Department of National Health and Welfare, and, since 1965, has been director of nursing, Prince Edward Island Hospital, Charlottetown.



Ella MacLeod



Wilhelmina Visscher

Wilhelmina (Willy) Visscher officially retired as assistant director of nurses of the Ottawa-Carleton Regional Area Health Unit, and is now coordinator of a local initiative project at MacDonald Manor in Ottawa's Lower Town East.

This program, for residents, most of whom are French-speaking, is called "Service for Both Ages" as it incorporates a senior citizen's project with a service to children in the area.

Ms. Visscher's nursing career has taken her trom her native Holland to the four corners of the earth, especially through her affiliation with the International Relief Organization and the World Health Organization. She had been with the health department of the city of Ottawa since 1958, except for a two-year assignment with WHO from 1963-5.

# Next Month in

# The Canadian Nurse

- Nurses, Smoking, and Schoolchildren
- When Parents Have A Defective Baby
- First Aid for Drivers
- The Self-Care Dialysis Unit



### Photo credits for lune 1973

Armour Landry, Montreal, Quebec, p. 6

T. Eaton Co., Toronto, Ont., p.34

### names

Beverly Witter Du Gas (R.N., Vancouver General Hosp. School of Nursing; B.A., U. of British Columbia; M.S., U. of Washington, Seattle; Ed.D., U. of British Columbia) has been appointed chief of the health manpower planning division, health programs branch, Health and Welfare Canada.



Currently first vicepresident of the Canadian Nurses' Association, Dr. Du Gas was a member of the committee on nursing education and of the board of examiners of the Registered Nurses'

Association of British Columbia.

Prior to leaving Vancouver in 1965 to join WHO as a nurse educator in India, she had been associate director of nursing education at The Vancouver General Hospital. Since 1969, Dr. Du Gas has been with the department of national health and welfare as nursing consultant for the health manpower planning division.

Helen (Leni) Nightingale (Reg.N., St. Joseph's Hospital School of Nursing, Toronto; Cert. Clin. Teaching and Superv., U. of Toronto; B.N., McGill U.) has been director of nursing, Brockville Psychiatric Hospital, Brockville, Ontario, for nearly a year.

During her career, centered largely on education, supervision, and administration in Toronto hospitals, Ms. Nightingale has devoted several years to industry as charge nurse for Continental Can Company of Canada.



Helen Nightingale



Marian Jackson

Marion Jackson has been appointed nursing administrator at Saskatoon City Hospital, Saskatchewan, effective June, 1973.

Ms. Jackson (B.Sc.N., U. of Saskatchewan; M.S.N., U. of British Columbia) has had experience as general staff nurse at University Hospital in Saskatoon and the Sudbury Memorial Hospital in Sudbury, Ontario, and as clinical instructor at Toronto Western Hospital and Regina Grey Nuns' Hospital. Prior to her recent educational leave, she was director of medical nursing at Saskatoon's University Hospital.

Ms. Jackson has had articles published in *The Canadian Nurse* and in *Nursing Clinics of North America*. She has contributed to her professional association by conducting workshops in Saskatchewan on clinical nursing and through membership on the board of examiners of the SRNA.



Donna Tudor (Reg. N., Atkinson School of Nursing, Toronto Western Hospital; Dipl. Public Health, U. of Toronto) became a member of the nursing staff of the Mississauga district office of the

Ontario Society for Crippled Children several months ago. She had previously been a public health nurse with the Ontario Department of Health, Scarborough.



Joan Ann Wills (Reg.N., Ottawa Civic Hosp. School of Nursing; B.Sc. Public Health Nursing, U. of Ottawa) now director of public health nursing of the Leeds, Grenville, and La-

nark District Health Unit, was a public health nurse with the unit from 1964 to 1967. Then, until her present appointment, she was assistant director, inservice education, at the Ottawa General Hospital.

An active member of the Registered Nurses' Association of Ontario, Ms. Wills is the past president of its Ottawa East chapter, having completed terms of office as treasurer and vice-president.

Antoinette Bourgeois of Grandc-Digue, a fourth-year nursing student from the University of Moncton, has been awarded a \$500 scholarship by the New Brunswick Association of Registered Nurses. She is the first recipient of the scholarship to be awarded annually to a student enrolled in the basic nursing program at the University of Moncton.

The scholarship was established last year at the Association's annual meeting to recognize deserving students in the province's French-language university school of nursing.

# AV aids

### **FILMS**

☐ Child Behaviour Equals You (16 mm, sound, color, 14½ min., 1972) was produced by Crawley Films for Carleton University and the Vanier Institute of the Family to promote community discussion of child development. The film, which uses animation, contains five segments that cover infancy, preschool, middle childhood, adolescence, and special situations. The behavior modification technique of positive reinforcement for good behavior is emphasized. This film is available from National Film Board offices or can be rented from the Canadian Film Institute, 1762 Carling Avenue, Ottawa K2A 2H7.

☐ Smoking: It's Your Choice (16mm. color, sound, 15 min.) is a film designed to help young people make a decision about smoking. Animation and contemporary music are used to help hold the viewer's attention. The film is available from Educational Film Distributors Ltd., 191 Eglinton Ave. E., Toronto 12, Ontario. Also available for sale or rental are films on adolescence, child development, old age, and community psychiatry.

Casual Ties, Casualties (16mm, color, sound, 13 min.) is designed to inform teenagers of the psychosocial aspects of venereal disease. It focuses on Penny, a young carrier of VD, and follows her through a free clinic. This film is available from International Tele-Film Enterprises, 221 Victoria Street, Toronto M5B 1V5, Ontario. As well as films on VD, films on safety, teenage pregnancy, and sex education are available from this source. A 180page master eatalogue includes listings of short films and feature films, and information on preview prints, rentals, and purchases of films.

☐ Generation (16 \(\frac{1}{2}\) min., color, sound), produced by Health and Welfare Canada, was shown at the annual meeting of the Canadian Nurses' Association last April. With a three-panel split screen and 10 synchronized slide projectors casting colorful images on the panels, viewers are given a jazzy look at Health and Welfare Canada's

AV Equipment Donated To Winnipeg School Of Nursing



The Winnipeg General Hospital school of nursing has received a donation of audiovisual equipment from a 1941 graduate of the school, Doris L. Turner. Shown with the equipment are, left to right, Ann Dinse, student council president; Jean Grose, director of nursing education; Verna Sparks, radio-therapy technician and registered nurse; and Kathleen DeMarsh, vice-president, nursing. The equipment shown on the table is, *left to right*, a Dukane Cassettmatic, a Bell and Howell movie projector, and a Bell and Howell overhead projector. The nurses are holding an Ektographic AV 120.

services. Short motion picture sequences are combined with the slides.

The photography is vivid and the music, which is always noticeable, at times is overpowering. The noise level may have been due to the size of the room. Although Generation may be technically excellent, it is difficult to find a message. Images are flashed on and off: young people taking drugs, city slums, the elderly, institutional facilities, and physical fitness. There is even a motion picture sequence showing the birth of a baby. There is no apparent order in the stages of life that are

According to the brochure that was given out at this showing, "Generation is a panorama of those activities and

services offered by Health and Welfare Canada to improve the quality of life of its citizens." More information is available from the department's Information Directorate, Brooke Claxton Building, Tunney's Pasture, Ottawa.

□ Purposes of Family Planning (16 mm, sound, color, 14 min., 1972) presents a variety of life-styles in giving information about pregnancy and health hazards, reasons for having children, and family planning. The film is aimed at senior high school and college students and adults. For more information, write to Moreland Latchford Productions Ltd., 299 Queen St. W., Toronto. Ontario.

# books

Psychology and Psychiatry for Nurses, 3ed., by Peter Dally and Susan

Farnham. 153 pages. London, England, English Universities Press, 1972. Canadian Agent: Musson, Don Mills, Ontario.

Reviewed by Marjorie Wallington, Assistant Professor, Lakehead University School of Nursing, Thunder

Bay, Ontario.

The purpose of this book, as stated in the introduction, is "... both for nurses in general training and those training as mental nurses." The book is divided into two parts: part one is called psychology and deals with a wide range of topics, such as developmental theory, personality theory, learning theories, the physical basis of psychology, and the nurse-patient relationship.

This section demonstrates two basic weaknesses throughout. On the one hand, it is written so simplistically it becomes inaccurate in its connotations. For instance, on page 3, the authors write: "The degree to which we can control our actions and conform to social demands determines whether we are strong or weak-willed and this depends on inherited and constitutional factors and on early upbringing."

On the other hand, the author frequently veers off into sentences of five- or six-syllable words with no explanation for the statement, such as, "Behavior can, in fact, be represented diagrammatically by a parallelogram of forces." The two short pages on the nurse-patient relationship are dreadful and should be left unread.

The first part of this book, however, does contain some basic facts that are both appropriate to this book and

accurate.

Part II of the book deals with a brief description of common mental illnesses, mental subnormality and their treatment. Although there is a fair degree of accuracy in the information, it is marked by an almost total absence of nursing intervention; yet, in reading the book, I have a feeling that the authors intended to cover this area.

Nursing intervention that is included would not always be consistent with the North American approach to psychiatric care. For example, in the section dealing with depressive illnesses only two statements are made that would give the nurse direction. These are: "A suicidal patient will need to be kept in bed, usually under heavy sedation and closely watched" and "Loss of weight must be restored and physical factors dealt with." Under treatments, the paragraph on group psychotherapy is described as a method of treating eight to ten patients at a time to overcome the time-consuming problem of dealing with individuals. The page that describes the therapeutic milieu is fairly well done.

There are two appendixes that include two pages on psychological theories and one page listing drugs in common use. The glossary presents the same shortcomings found throughout the book — inaccuracy through over-

simplicity.

Although statistical facts and authors are quoted throughout the book, there is no documentation either through

footnotes or bibliography.

A concise book of this size would be useful to nurses working with psychiatric patients, either in general hospitals or in the community; however, I cannot recommend this volume to fill that gap.

Because I believe this book is inconsistent with the patient-centered approach and the importance of the therapeutic relationship, which is basic to psychiatric nursing in this country, I cannot recommend it for teaching nurses.

Modern Clinical Psychiatry, 8ed., by Lawrence C. Kolb. 694 pages. Toronto, Saunders, 1973.

Reviewed by Carole TenBrink-Ho, School of Nursing, McGill University, Montreal, Quebec.

This text by Kolb (formerly Noyes and Kolb) has long been a basic but tradition-minded reference in its field. The new eighth edition, published this year, continues that trend. Efforts to update are done in a conservative way. The concerns of progressive practitioners in psychiatry are given brief, cautious mention.

Poverty and racism as causes of mental illness are mentioned in two pages and called predisposing factors. The communication theories, crisis intervention, community psychiatry, home care, and prevention are not mentioned at all. The expressive therapies, like psychodrama and art therapy, are also omitted. Encounter groups are discussed in one paragraph in which the writer mainly emphasizes that they can be destructive. Positive outcomes are not mentioned.

There is a two-page description of general systems theory, and brief mention of psychiatric implications in some of the new medical treatments, like hemodialysis, open heart surgery, organ transplants, and sex change

operations.

The greatest and most useful change, especially for school and public health nurses, is the expansion of a chapter on the disorders of early life and the new chapter on special symptoms in children. In these chapters is some wellpresented material on learning disturbance, speech disturbance, hyperkinetic reaction, withdrawn aggressive reaction. Family therapy is given two pages in the chapter on current therapies but is not mentioned at all as a treatment of choice in families where a disturbed child is

In summary, one can only reemphasize that the text remains a basic, useful first reference for those wanting information on psychiatric classifications, examination of the patient, and traditional psychotherapeutic, pharmacological, and physical therapies.

Psychiatric Nursing as a Human Experience by Lisa Robinson. 352 pages. Toronto, W.B. Saunders Company, 1972.

Reviewed by Merryl Etches, Lecturer, School of Nursing, The University of Manitoba, Winnipeg, Man.

In the psychiatric segment of her education, the nursing student "becomes aware of some of the bases for her own perceptions of life's experiences; she acquires the knowledge to understand that all behavior has meaning and that all human beings are basically more similar than dissimilar." This statement in the opening chapter of the book illustrates the author's focus for nursing intervention.

The first three chapters examine the nurse-patient relationship, emphasizing the nurse's awareness of self. Some specific concerns of the student embarking on her psychiatric experiences are thoughtfully discussed. The description of the components of the therapeutic relationship. communication, caring, trust, love, and empathy emphasizes the uniqueness of the person. "The psychiatric nurse must regard her patient as a unique composite of spirit, intellect and feelings that must be nurtured and allowed to grow."

An interesting view is that anxiety, both nurse's and patient's, is an element that can be a positive factor in the nurse-patient relationship. Examples of interaction illustrate the author's explanation of interviewing techniques and the concept that techniques are useful only if used "wisely and spar-

ingly" in a caring context.

Defense mechanisms are defined as a means of regaining and maintaining psychological equilibrium in a healthillness continuum. The discussion on growth and development is eclectic. The author shows great skill in drawing from several theorists, including Freud, Sullivan, and Erikson, to explain this difficult area in a manner understood by the beginning student.

In chapters six to eight, the etiology, behavioral manifestations, and nursing in anxiety, depression, and withdrawal behavior are explored. The title of the chapter on schizophrenia, "The Patient Who is Unable to Reach Out." is illustrative of the focus on the human

being rather than the disease.

Descriptions of care in state hospitals and the community and of types of therapy: chemotherapy, convulsive therapies, insulin shock, psychosurgery, group therapies, milieu therapy, psychodrama, the encounter group, and family therapy are given. Although brief, these descriptions are coneise and give the reader a general idea of treatment methods available and the progress made through the years.

Chapters 12 to 15 focus on specific problems: alcohol and drug abuse, psychiatric illness from organic causes, and mental retardation. A chapter on emotional and mental illness in children, written by Leona Weiner, associate professor, department of nursing, Long Island University, Brooklyn, N.Y., outlines special considerations in the diagnosis, treatment, and nursing intervention with children and adolescents. Anyone working with children would want to enlarge her understanding through the comprehensive readings suggested.

The author's continual emphasis on the patient as a human being who needs help and whose problems are

not vastly different from the student's make this text a valuable addition to the literature available for the beginning student in psychiatric nursing.

Casebook in Nursing Education by Vivian Wood. 301 pages. London, University of Western Ontario, 1972. Reviewed by Raymond M. Thompson, Assistant Professor, University of British Columbia, School of Nursing, Vancouver, B.C.

The author of this all-Canadian publication states that "this book aims to facilitate development of those [decision-making] skills" required by nurse educators in dealing with student nurse problems.

In her prefacing remarks, the author elaborates on the nature and the content of her book, including the variety of skills and methodology required in the use of the complex case as an intensive learning experience. It is essential that we appreciate the complexity of the eases presented: the problems are not clearly identified; the critical elements may or may not be readily identifiable; and the relationships between and among the included data may be obscure.

This easebook was designed for the use of graduate students; therefore, any discussion or analysis has been

omitted.

The learning process used in the ease method approach (which is not extensively outlined in the book) can be viewed as analagous to the scientific method/problem-solving approach. Due to the complex nature of each situation presented, each aspect and item of data must be closely scrutinized. Following this, relationships between and among the data and problem areas can be identified. Solutions may then be proposed, the consequences of each analyzed, whereupon a well-analyzed decision regarding the problem(s) may be recommended. Group discussion and dynamic interaction are crucial throughout the process.

It may be helpful if the user of this book attempts to comprehend totally the milieu of each case, thereby achieving greater insight and comprehension.

The 18 cases presented focus upon common nursing education problems, such as admissions, counseling, evaluation, and psychiatric problems, as well as other major student personnel issues. It is notable that each case has been researched under expert supervision and the data within each represents the current realities of nursing education.

Minor errors, which normally should be easily resolved by the reader, but



Ventfoam Traction Band has everything you want and your patients need for comfort and healing.

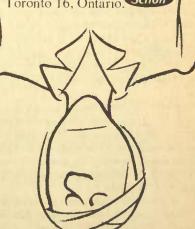
The perforations allow skin to breathe, inducing more rapid healing of lesions.

The Ventfoam Traction Band is the strongest in its field. Made of super soft foam rubber, laminated to a fine rayon twill backing, it has a tensile strength of over 100 pounds.

It's hypoallergenic. It comes in 3 and 4 inch widths, in handy 64 inch packages.

Let us demonstrate the Ventfoam Traction Band for

Surgical Supply Division, Scholl (Canada) Inc. 174 Bartley Drive, Toronto 16, Ontario. Scholl



may be initially distracting, occur so infrequently that they do not interfere with the quality and value of the cases.

Dean Aikin's foreword tends to be slightly misleading by inferring that the text will be useful in areas of nursing other than the audience for whom the book was designed; the level of sophistication required to gain maximum benefit of analyzing the cases may be beyond the preparation of current nursing educators.

The anticipated publication of a volume of teaching notes should enhance the value of this text. In the interim, the references and bibliography included by the author should provide sufficient and useful information relating to the cases presented. Additional helpful references would be: Ms. Wood's recent article "The Drug Incident — A Case Study," *The Canadian Nurse*, July, 1972, pp.21-6, and Schnelle, Kenneth E., *Case Analysis and Business Problem Solving*, Toronto, McGraw-Hill Book Company, 1967.

The value of this book, to those not involved in the specific course for which it was designed, is that it focuses upon issues, factors, and considerations that may have previously eluded those involved in nursing education.

### accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, except reference items, may be borrowed by CNA members, schools of nursing and other institutions. Reference (R) items (archive books and directories, almanacs and similar basic books) do not go out on loan. Theses (also R) are on Reserve and may go out on Interlibrary loan only.

Request for loans should be made on the "Request Form for Accession List" and should be addressed to: The Library, Canadian Nurses' Association, 50 The Driveway, Ottawa, Ont. K2P 1E2.

No more than *three* titles should be requested at any one time.

### BOOKS AND DOCUMENTS

- 1. Accreditation manual for psychiatric facilities, 1972. Chicago, Ill., Joint Commission on Accreditation of Hospitals, 1972. 170p.
- 2. Alexander's care of the patient in surgery, by Walter F. Ballinger et al. 5ed. St. Louis, Mosby, 1972. 905p.
- 3. Les analyses médicales: prélèvements et résultats, par Maurice Diesnis. 5éd. Paris, Librarie le François, 1972, 794p.

- 4. Anatomie, par John V. Basmajian. 6éd. Traduit de l'américain par les docteurs F. et R.-H. Polge d'Autheville. Paris. Maloine; St. Hyacinthe, P.Q., Somabec, 1972. (c1970 by Williams & Wilkins, Baltimore) 416p.
- 5. Apprendre à être, par Commission internationale sur le développement de l'éducaion. Paris, Fayard (for Unesco) 1972. 368p. Président: Edgar Faure.
- 6. Arithmetic in nursing, by William C. Fream. Rev. by R.P. Davies. 4ed. London, Baillière Tindall, 1972. 210p.
- 7. Behavior and illness, by Ruth Wu. Englewood Cliffs, N.J., Prentice-Hall, 1973. 211p. 8. A cancer source book for nurses. New York, American Cancer Society, Inc., 1963. 120p.
- 9. The challenge of nursing; a book of readings, by Margaret E. Auld and Linda Hulthen Birum. St. Louis, Mosby, 1973. 247p.
- 10. The Ciba collection of medical illustrations, by Frank Henry Netter. Summit, N.J., Ciba Pharmaceutical. 1953-1972. 5v. in 7 R
- 11. The clinical nurse specialist: an experiment in role effectiveness and role development, by Rachel Ayers. Final project report prepared by Geraldine V. Padilla et al. Duarte, Calif., City of Hope National Medical Center 1971, c1972, 75p.
- 12. Community Health Centre Project. The community health centre in Canada; report to the Conference of Health Ministers.
  Ottawa, Information Canada, 1972. 2 vols.
- 13. Continuing education in nursing; a review of North American literature 1960-1970, by June Nakamoto and Coolie Verner, Vancouver, Adult Education Research Centre and Division of Continuing Education in the Health Sciences, University of British Columbia, 1972, 88p.
- 14. Cours de sexologie, par Serge Mongeau. Montréal, Editions du Jour, 1968-1970. 5 vols.
- 15. Current nommedical drug use; a guide, by Jason Kelley. 3ed. Rev. & expanded by David Velinder & Jim Waltner. Dallas, Texas, Tuatara, 1972, 55p.
- 16. Dictionnaire des media: technique, linguistique, sémiologie, par Jean-Baptiste Fages et al. (n.p.) HMH, 1971. 350p.
- 17. The discipline and teaching of nursing process; an evaluative study, by Ida Jean Orlando. New York, Putnam, 1972. 126p.
- 18. Dynamics of groups at work, by Herbert A. Thelen. Chicago, University of Chicago Press, 1954. 374p.
- 19. Final report on International Conference on Adult Education, 3rd, Tokyo, 25 July 7 Aug., 1972. Paris, Unesco, 1972. 101p.
- 20. Moral dilemnas in medicine; a course book in ethics for doctors and nurses, by Alastair V. Campbell. London, Churchill Livingstone, 1972, 214p.
- 21. Need for subsidized family planning services: United States, each state and county, 1969. A report...for the Executive Office of the President, Office of Economic Opportunity. New York, Planned Parenthood-World Population Center for Family Planning Program Development, 1972. 328p.
- 22. Nursing service in transition: a des-

- cription of organization for classification and utilization of nursing practitioners, by Rachel Ayers. Duarte, Calif., City of Hope Medical Center, 1972, 124p.
- 23. Old age, by Simone de Beauvoir. Translated by Patrick O'Brian. London, André Deutsch and Weidenfeld and Nicolson, 1972. 585p.
- 24. Ophthalmology; principles and concepts, by Frank W. Newell. 2ed, St. Louis, Mosby, 1969. 527p.
- 25. Pharmacie, par Yvan Touitou. 3éd. Paris, Masson, 1972. 260p.
- 26. Pharmacology in nursing, by Betty S. Bergersen and Andres Goth. 12ed. St. Louis, Mosby, 1973. 682p.
- 27. Physiology of hormonal contraceptives. Geneva, WHO Medlars Centre, 1972, 246p. 28. A pocket gynaecology, by Stanley G.
- Clayton. 7ed. Condon, Churchill Livingstone, 1972. 135p.
- 29. A pocket obstetrics, by Stanley G. Clayton. 7ed. London, Churchill Livingstone, 1972. 152p.
- 30. Pourquoi des infirmières? par Catherine Mordacq. Paris, Centurion, 1972. 111p.
- 31. The prevention of perinatal morbidity and mortality. Report on a Seminar, Tours, 22-26 April, 1969. Geneva, World Health Organization, 1972. 97p. (Its Public Health papers no. 42)
- 32. Reform in graduate education, by Lewis B. Mayhew. Atlanta. Ga., Southern Regional Education Board, 1972. 182p. (SREB Research monograph no. 18)
- 33. Side effects of hormonal contraceptives. Geneva, WHO Medlars Centre, 1972. 212p.
- 34. Survey questionnaire. Chicago Ill., Joint Commission on Accreditation of Hospitals, Accreditation Council for Psychiatric Facilities, 1972. I vol.

### PAMPHLETS

- 35. Education permanente et formation en cours d'emploi, par Rollande Gagné. Montréal, Intermonde, 1972. 4p.
- 36. Family in Britain. London, Office of Health Economics, 1972. 40p. (Its Studies on current health problems no. 40)
- 37. General Nursing Council for England and Wales, 1919-1969. London, 1971? 20p.
- 38. Guidelines for the preparation of a nursing service policy manual, by Doris E. Skoog. Hartford, Conn., Connecticut State Department of Health, 1971. 37p.
- 39. Learning to be; summary of report of International Commission on the Development of Education. Ottawa, Canadian Commission for Unesco, 1973. 8p. (Unesco Occasional paper no. 9) Chairman: Edgar Faure.
- 40. Maintaining health—an adventure in transition. Proceedings of the fourth Mid-Atlantic Regional Conference, sponsored by the Mid-Atlantic Regional Assembly of the National League for Nursing held at New York, June 9, 1972. New York, National League for Nursing, 1973. 37p.
- 41. Mémoire présenté à la Commission parlementaire hargée d'étudier les commentaires concernant le projet de loi sur

les professions, (Bill 250). Montréal, Association des Gardes-Malades et Infirmiers Auxiliaires de la Province de Québec, 1972. 5p.

42. The nurse practice act of New York state as contained in articles 130 and 139 of title 8 of the New York state, including amendments enacted through June, 1972. Albany, New York State Nurses' Association, 1972. 15p.

43. Nursing resources in Newfoundland. An analysis of the current situation: projections regarding supply and requirements, by Association of Registered Nurses of New foundland, Beverly W. Du Gas and Roberta M. Samets. St. John's, 1972. 8p.

44. Resolutions approved at Joint CMAl CNA|CHA Conference, health action '72, Mont Gabriel, Sep. 23-24, 1972. Ottawa. Canadian Nurses' Association, 1972. 3p.

45. State health manpower planning; a policy overview, by Jan Acton and Robert Levine. Santa Monica, Calif., Rand, 1972, 28p.

### GOVERNMENT DOCUMENTS

Canada

46. Commissioner of Official Languages. *Report 1971-72*. Ottawa, Information Canada, 1973. 278p.

47. Dept. of National Health and Welfare. Earnings of physicians in Canada, 1960-1970. Ottawa, 1972. 45p. (Health care series no. 29)

48. —. The intensive group experience; description and guidelines. Ottawa, 1973.

12p. (Canada's mental health supplement no. 73)

49. — Methods involved in successful and unsuccessful attempts to stop smoking (personality factors); a report by F.R. Wake. Ottawa, 1968. 14p.

50. Dept. of Veterans Affairs. Report, 1970/71. Ottawa, Information Canada, 1971, 101p.

51. Groupe d'étude sur l'ordinateur et la vie privée. L'ordinateur et la vie privée. Ottawa, Information Canada, 1972. 239p.

52. Ministère des Affaires anciens comattants. *Rapport*, 1970/71. Ottawa, Information Canada, 1971. 107p.

53. National Film Board of Canada. Report, 1970/71. Ottawa Information Canada, 1971. 67n

54. Office national du film du Canada. *Rapport* 1970/71. Ottawa, Information Canada, 1971, 71p.

55. Science Council of Canada. Facts and figures. Ottawa, 1972. 14p.

56. Statistics Canada. Hospital morbidity: Canadian diagnostic list, 1969. Ottawa, Information Canada, 1972. 71p.

57. Statistique Canada. La morbidité hospitalière: liste canadienne de diagnostics, 1969. Ottawa, Information Canada, 1972. 71p.

58. Task Force on Privacy and Computers. *Privacy and computers*. Ottawa, Information Canada, 1972, 236p.

Ontario

59. Dept. of Health. Research and Analysis Division. The expanded role of the nurse

in primary health care. A summary of current developments. Toronto, 1973, 72p. R

60. Ministère de l'Education. *Opération science de la santé*. Québec, . . . en collaboation avec le Ministère des Affaires sociales, 1972, 19p.

United States

61. National Center for Health Statistics. Employees in nursing homes: United States — April-September 1968. Washington. Public Health Service, 1972. 57p. (Vital and health statistics series 12, no. 15)

STUDIES DEPOSITED IN CNA REPOSITORY
COLLECTION

62. Research and studies on nursing in Israel. Tel-Aviv, Tel-Aviv University, Faculty of Continuing Medical Education, Dept. of Nursing, 1972. 12p. R

63. The road back from invalidism; an evaluation study of patients with long-term illnesses following rehabilitative medical treatment in a pilot unit within a general hospital, by Phyllis Giovannetti and Lawrence E. Ranta. Vancouver, B.C.. Vancouver General Hospital, 1969. 49p. R

64. A study of organizational effectiveness: the Association of Registered Nurses of Newfoundland, by O.P. Hughes and R.R. Roskin. St. John's, 1972, 45p. R

65. A study on the three major roles of provincial nurses' organizations, by Soeur Madeleine Bachand. Ottawa, Canadian Nurses' Association, 1973. 48p. R

### Request Form for "Accession List" CANADIAN NURSES' ASSOCIATION LIBRARY

Send this coupon or facsimile to: LIBRARIAN, Canadian Nurses' Association, 50 The Driveway, Ottawa K2P 1E2, Ontario.

Please lend me the following publications, listed in the issue of The Canadian Nurse, or add my name to the waiting list to receive them when available.

Item

Author

Short title (for identification)

Request for loans will be filled in order of receipt.
Reference and restricted material must be used in the CNA library.

Borrower

Registration No.

Position

Address

Date of request

A New Family Planning Booklet



"Once a month the egg travels..." is a new booklet for your patients. Fully illustrated throughout, it describes the methods of contraception. Comparative pregnancy rates are given for each method along with a list of additional sources for family planning information.

To receive your free booklet(s) please fill in the coupon.

	To: Miss E. Dawson, R.N. Director of Educational Services Ortho Pharmaceutical (Canada) Ltd. 19 Green Belt Drive, Don Mitls, Ontario. M3C 1L9
i	Please send me copies in English of "Once a month the egg travels"
į	Veuillez m'envoyerexemplaires en francais de "Une fois par mois, l'oeuf se déplace…"
I	NAME
į	ADDRESS
-	POSITION

© ORTHO 1973

### classified advertisements

ALBERTA

Myrnam Municipal Hospital requires 2 GENERAL DUTY NURSES. Salaries in accordance with AARN recommendations and recognition granted for past experience. Lodging available in nearby nurses residence. Excellent communication to Edmonton and other major cities. Area provides boating, fishing and golfing tacilities. Apply to: Mrs. R. Marko, N/S. or phone 366-3870, Myrnam, Alberta.

ALBERTA

**BRITISH COLUMBIA** 

DIRECTOR OF NURSING: Applications are invited for the position of Director of Nursing for a modern fifty-six bed hospital in the Lakes District of the Central Interior of B.C. Applicants holding a degree in Nursing or a University diploma in Supervision preferable. Satisfactory administrative experience essential. Apply to: (Miss) Doris O.R. Allin, Administrator, Burns Lake and District Hospital, Box 479, Burns Lake, British Columbia.

DIRECTOR OF NURSING — June 1st — FOR 21-BED ACUTE GENERAL HOSPITAL NEAR LONG BEACH. APPLICANTS SHOULD HAVE DEGREE OR DIPLOMA IN NURSING SERVICE ADMINISTRATION WITH SOME PREVIOUS EXPERIENCE IN A SUPERVISORY POSITION. SALARY COMMENSURATE WITH OUALIFICATIONS AND EXPERIENCE. WRITTEN APPLICATIONS TO: ADMINISTRATOR, TOFINO GENERAL HOSPITAL, TOFINO, BRITISH COLUMBIA.

VACANCY FOR HEAD NURSE, MEDICAL-SURGICAL AREA. Progressive experience in nursing field with at least one year as a general duty nurse. Graduation form accredited school of nursing; preterably a Bachelor of Science in nursing; current B.C. registration; advanced preparation in administrative nursing techniques, including ward management and principles of supervision or its equivalent. Apply to: Mrs. A. Simpson, Acting Director of Nursing, Victoria General Hospital, 841 Collinson St., Victoria, British Columbia General Hospita British Columbia

NURSING CO-ORDINATOR (Supervisor) for Obstetrical and Gynecological Services — HEAD NURSE for Obstetrical/Gynecological ward. Progressive department with family-centred approach to patient care. Apply to: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

INTENSIVE CARE UNIT TRAINED NURSES required for 120-bed General Hospital. Salary as per RNABC contract. Nurses' Residence accommodation available. Apply to: Director of Nursing, Powell River, General Hospital, 5871 Arbutus Street, Powell River, British Columbia

OPERATING ROOM NURSE wanted for active modern acute hospital. Four Certified Surgeons on attending staff. Experience or training desirable. Must be eligible for B.C. Registration. Nurses residence available. Salary \$687 per month starting Apply to: Director of Nursing, Mills Memorial Hospital, 2711 Tetrault St., Terrace, British Columbia.

GENERAL DUTY AND OPERATING ROOM NURSES FOR THE POINT AND OPERATING ROOM NURSES for modern 450-bed hospital with School of Nursing. RNABC policies in effect. Credit for past experience and postgraduate training. B.C. Registration required. For particulars write to Acting Director of Nursing Service. Victoria General Hospital, Victoria, British Columbia.

Positions available for REGISTERED NURSES for general duty in the Operating Room, Surgical, the Care and Extended Care areas. MALE REGISTERED NURSES are required for the 20-bed Psychiatric ward. Salaries and Personnel Policies in accordance with the RNABC agreement. Apply to the Director of Nursing, Chilliwack General Hospital. Director of Nursing, Chilli Chilliwack, British Columbia

BRITISH COLUMBIA

REGISTERED NURSES AND LICENSED PRACTICAL NURSES WANTED FOR FULLY ACCREDITED HOSPITAL EXPANDING TO 190 BEDS IN THE FALL OF 1973. ADMINISTRATIVE, SUPERVISORY AND GENERAL DUTY CATEGORIES IN MEDICAL-SURGICAL, PSYCHIATRIC AND ICU-CCU AREAS MUST BE ELIGIBLE FOR B.C. REGISTRATION. BASIC SALARY \$672.00. APPLY: DIRECTOR OF NURSING, ST. JOSEPH'S GENERAL HOSPITAL, COMOX, BRITISH COLUMBIA.

REGISTERED NURSES required for Nicola Valley General Hospital, located in the Southwestern part of B.C. Starting salary from \$672.00 to \$740.00 depending on experience. Residence available. Apply to: Director of Nursing, N.V.G.H., P.O. Box 129, Merritt, British Columbia.

EXPERIENCED NURSES required in 409-bed acute Hospital with School of Nursing. Vacancies in medical, surgical, obstetric, operating room, pediatric and Intensive Care areas. Basic salary \$672.—\$842. B.C. Registration required. Apply: Director of Nursing. Royal Columbian Hospital. New Westminster, British Columbia.

EXPERIENCED GENERAL DUTY NURSES — required for small up-coast hospital. Salaries start at \$672.00. Residence accommodation at \$25.00 per month. 20 days annual vacation. Transportation paid from Vancouver, B.C. Apply Director of Nursing, St. George's Hospital, Alert Bay, British Columbia.

GENERAL DUTY NURSES, for modern 35-bed hospital located in southern B.C.'s Boundary Area with excellent recreation facilities. Salary and personnel policies in accordance with RNABC. Comfortable Nurses's home. Apply: Director of Nursing. Boundary Hospital, Grand Forks, British Columbia.

MANITOBA

REGISTERED NURSE required for general duty in a 25-bed hospital in Central Manitoba, room and board available. For application forms and fuller details apply to: Director of Nursing, Gladstone District Hospital, Box 250, Gladstone, Manitoba, ROJ 0TO.

ONTARIO

REGISTERED NURSES required by 70-bed General Hospital situated in Northern Ontario, Salary scale — \$610.00 — \$720.00 allowance for experience. Shift differential, annual increment. 40 hour week. Excellent personnel policies. For particulars apply Director of Nursing, Lady Minto Hospital at Cochrane. Cochrane, Ontario

REGISTERED NURSES for 34-bed General Hospital. Salary \$646. per month to \$756. plus experience allowance. Excellent personnel policies. Apply to Director of Nursing Englehart & District Hospital Inc., Englehart, Ontario.

REGISTERED NURSES required for a new 79-beo General Hospital in bilingual community of Northern Ontario, French tanguage an asset, but not compulsory. Salary is \$645 to \$758. monthly with allowance tor past experience. 4 weeks vacation atter 1 year and 18 sick leave days per year. Unused sick leave days paid at 100% every year. Master rotation in effect. Rooming accommodations available in town. Excellent personnel policies. Apply to Personnel Director, Notre-Dame Hospital, P.O. Box 850. Hearst, Ont.

WANTED: ASSISTANT EXECUTIVE DIRECTOR — NURSING 400-bed active Convalescent-Rehabilitation Hospital including 100-beds for School Hospital activities. Large Departments of Nursing, Physiotherapy, Occupational Therapy, Psychology, Speech/Audiology, Social Service, and Recreational Therapy, A busy Out-Patient Department provides for Assessment Clinics, Meningomyelocele, Convulsive Disorders, etc., mainly involving children. This is the top position in the Nursing establishment. A Master's Degree is preferred and salary is competitive. Write to: W.G. McPhail, M.D., Executive Director, Glenrose Provincial General Hospital, 10230—111 Avenue, Edmonton, Alberta T5G 0B7.

EMPLOYMENT OPPORTUNITY — Athabasca Health Unit No. 18 requires a Senior Nurse immediately for the Athabasca Unit Office. Diploma in Public Health preferred but not essential. Salary in accordance wifn the L.H.S. 12 Salary Schedule plus 8%. Salary range of Senior Nurse (without DPHN) 7200 — 8280 plus 8%. — Senior Nurse (with DPHN) 7200 — 8280 plus 8%. — or Senior Nurse with (BSc Public Health) 8280 — 9328 plus 8%. Salary range varies according to qualifications and experience. Send application to: Mr. V. Markowski, Secretary-Treasurer, Athabasca Health Unit No. 18, P.O. Box 1140, Athabasca, Alberta.

REGISTERED NURSES required for a 30-bed Gen-ral Hospital, salary and Personnel Policies as per AARN. Location of hospital, 80 miles east of Lacom-be, Highway No. 12. For more information write or phone 882-3434, Director of Nursing, Our Lady of the Posary Hospital, Castor, Alberta.

### **ADVERTISING** RATES

FOR ALL CLASSIFIED ADVERTISING

\$15.00 for 6 lines or less \$2.50 for each additional line

Rates for display advertisements on request

Closing date for copy and cancellation is 6 weeks prior to 1st day of publication

The Canadian Nurses' Association does not review the personnel policies of the hospitals and agencies advertising in the Journal. For authentic information, prospective applicants should apply to the Registered Nurses' Association of the Province in which they are interested in working.

Address correspondence to:

Canadian

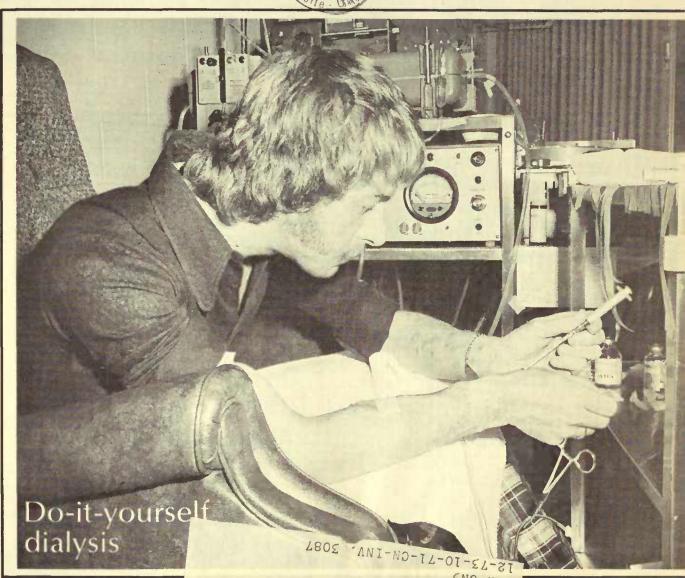


50 THE DRIVEWAY OTTAWA, ONTARIO K2P 1F2

# The Canacian Nursing Nursing

July 1973

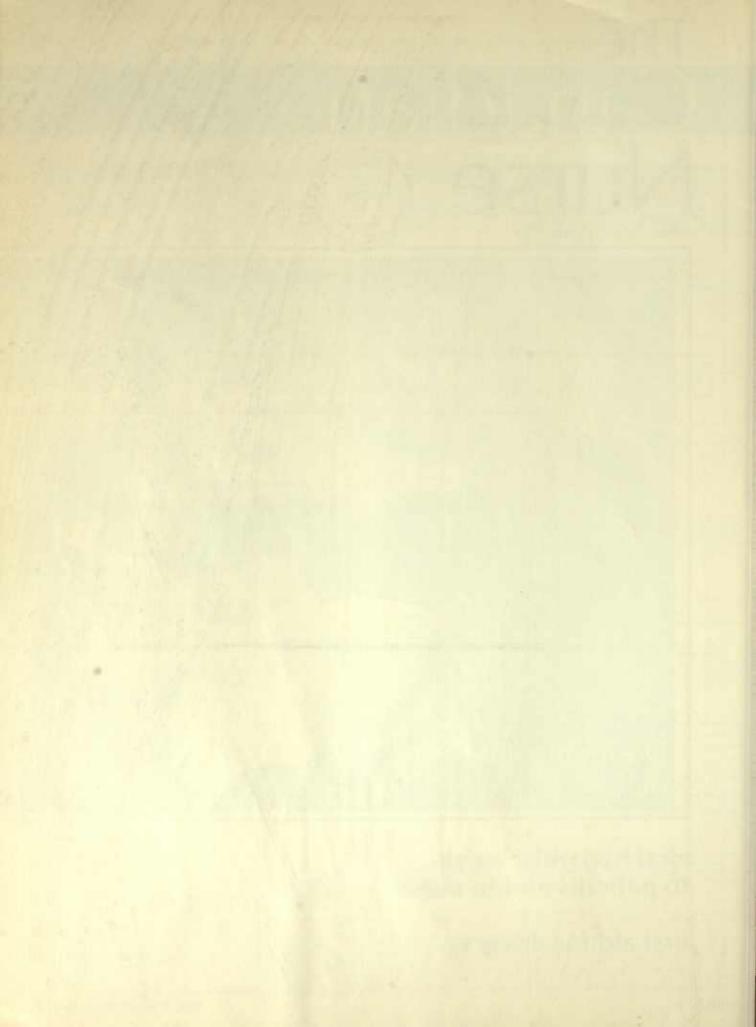
OUT OF LIERARY



viral hepatitis: a risk to patients and to nurses

first aid for drivers

UNIVERSITY OF OTTAWA NURSING LIBRARY ONT. CATA CONT.



# Lippincott

Further insight for to-day's





NURSING OF PEOPLE WITH
CARDIOVASCULAR PROBLEMS
Armington and Creighton
... emphasizes an integrated human approach
for optimum patient recovery during rehabilitation.

Little, Brown \$10.50
NURSING MANAGEMENT FOR PATIENT CARE
Beyers and Phillips

... integrates theory with a pragmatic approach to nursing management problems.

Little, Brown flexible cover \$ 5.95 cloth \$ 9.95

3 NURSING CARE OF THE LONG TERM PATIENT

Blumberg and Drummond
... presents relevant techniques and procedures of eight key concepts in patient manage-

ment.
Springer \$ 4.25

PERSONAL, IMPERSONAL AND INTERPERSONAL RELATIONSHIPS

... how to recognize the needs of patients; how to listen; how to counsel.

Springer \$ 4.50
INTENSIVE CARE FOR NURSES

Clark and Barnes
. . . demonstrates use of electronic and mechanical equipment with nursing techniques.
Blackwell \$ 4.50

DUNCAN'S DICTIONARY FOR NURSES

Duncan

. . . covers more than 10,000 terms the R.N. needs to know in nursing, medicine, psychiatry, and the social and biological sciences.

 7 MODERN MEDICINE FOR NURSES

... this new edition has been revised and brought up to date throughout.

Blackwell \$8.50

ESSENTIALS OF ABDOMINAL OSTOMY CARE
Honesty

... describes the care of abdominal stomas in patients who have had colostomy, ilcostomy, cecostomy and urinary diversion operations.

Springer \$ 3.75

DEVELOPING THE ART OF UNDERSTANDING

Johnson

... helps see the patient as a person and develop the emotional maturity needed to function in the supportive role.

Springer \$ 5.00

THE PSYCHOLOGY OF DEATH

Kastenbaum and Aisenberg
... "So well written ... an intelligent reader picking up their book out of mere curiosity might easily read through — and finish the book the beneficiary of a deepening experience." Publishers Weekly.

ence." Publishers Weekly.
Springer \$11.99

RENAL NURSING

. . . presents detailed instruction in the management of acute and chronic renal failure.

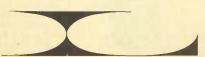
Blackwell \$ 4.50

12 ACUTE CORONARY CARE
Whipple et al.

. . . emphasizes physiological, psychological and rehabilitative aspects of patient care.

Little, Brown flexible cover \$10.50

cloth \$15.50



Serving the health professions in Canada since 1897 J. B. Lippincott Co. of Canada Ltd.

75 Horner Ave. Toronto, Ontario M8Z 4X7

Representing in Canada: Little, Brown and Company Blackwell Scientific Publications Ltd. Springer Publishing Company, Inc.

Please send me the book(s) whose number(s) I have circled					
1	5	9			
2	6	10			
3	7	11			
4	8	12			
Name	Position				
Address					
City	Province				
☐ Payment enclosed (send postpaid)  Books may be returned within 15 days	☐ Use my Chargex num ☐ Charge and bill me	berCN7-73			

6

# GRADUATE WITH HONORS



For a complimentary pair of white shoelaces, folder showing all the smart Clinic styles, and list of stores selling them, write:

THE CLINIC SHOEMAKERS • Dept. CN-7, 7912 Bonhomme Avenue • St. Louis, Mo. 63105

THE CANADIAN NURSE

[ULY 1973]

# The Canadian Nurse



A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 69, Number 7

July 1973

The views expressed in the editorial and various articles are those of the authors and do not necessarily represent the policies or views of the Canadian Nurses' Association.

4	Letters	
7	News	

16 Names39 In A Capsule

13 New Products

40 Books

15 Dates

44 Accession List

Executive Director: Helen K. Mussallem • Editor: Virginia A. Lindabury • Assistant Editors: Liv-Ellen Lockeberg, Dorothy S. Starr • Editorial Assistant: Carol A. Dworkin • Production Assistant: Elizabeth A. Stanton • Circulation Manager: Beryl Darling • Advertising Manager: Georgina Clarke • Subscription Rates: Canada: one year, \$6.00; two years, \$11.00. Foreign: one year, \$6.50; two years, \$12.00. Single copies: .75 cents each. Make cheques or money orders payable to the Canadian Nurses' Association. • Change of Address: Six weeks' notice; the old address as well as the new are necessary, together with registration number in a provincial nurses' association, where applicable. Not responsible for journals lost in mail due to errors in address.

Manuscript Information: "The Canadian Nurse" welcomes unsolicited articles. All manuscripts should be typed, double-spaced, on one side of unruled paper leaving wide margins. Manuscripts are accepted for review for exclusive publication. The editor reserves the right to make the usual editorial changes. Photographs (glossy prints) and graphs and diagrams (drawn in india ink on white paper) are welcomed with such articles. The editor is not committed to publish all articles sent, nor to indicate definite dates of publication.

Postage paid in cash at third class rate MONTREAL, P.Q. Permit No. 10,001. 50 The Driveway, Ottawa, Ontario. K2P 1E2

Canadian Nurses' Association 1973.

I well remember the first time I encountered a car accident and found it necessary to take charge and give on-the-spot first aid. It was a revealing experience.

Several persons stood staring at the victims, doing nothing to help them. Others were running frantically back and forth from one car to another, telling motorists what had happened. No one had assumed leadership.

As a nurse, I was able to rap out some directions to those standing by, and to help give basic first aid to the injured.

Since then, I have come across other car accidents. And, with few exceptions, I have found the same thing: an appalling lack of knowledge on the part of laymen as to what should be done and how to do it.

This month we feature an article by Dr. Hanns Pacy, author of Road Accidents — Medical Aid. His message is that drivers must be taught what to do at the scene of an accident and that it is the responsibility of the health professions "to promote and inspire the teaching of first aid."

Several measures Dr. Pacy mentions are of interest to all drivers, including nurses who supposedly have knowledge of first aid.

Dr. Pacy's recommendations result from his experience as a member of a rescue team in Australia. His personal observations of motorists' behavior at the scene of accidents lead him to write: "... victims of accidents continue to die on our roads because people do not know what to do when confronted with traffic injuries. The best hospital is of no use if the patient is already dead or beyond help."

Nurses, as well as doctors, do, indeed, have a responsibility "to promote and inspire the teaching of first aid." Our concern could well save the lives of persons who would otherwise be D.O.A. — V.A.L.

# letters

Letters to the editor are welcome.

Only signed letters, which include the writer's complete address, will be considered for publication.

Name will be withheld at the writer's request.

Comments on laparoscopy

After reading the articles on laparoscopy in the April issue, I would like to make a few comments regarding our experience in the St. Thomas-Elgin General Hospital, St. Thomas, Ontario.

In the last two years, we have successfully completed about 1,200 similar operations on a one-day, outpatient basis. Patients and their husbands come to the admitting department usually by 7:00 A.M. and sign consent forms; this is witnessed by hospital staff members.

The patients are then taken to a unit with four stretcher beds, where they have their temperature, pulse, respiration, and blood pressure taken. A hemoglobin and urinalysis are also done. The surgeon visits each patient, does a brief examination, and takes a

current history.

One-half hour before surgery, patients are instructed to void, and a preoperative medication is given. The method of sterilization is basically the same as described in the April articles. Using the abdominal approach, a single incision is made at the navel. One absorbable suture is placed in the

incision.

Recovery of these patients is usually speedy. Most are up and void within two to four hours, have a light lunch, and are discharged between 1:30 P.M. and 3:30 P.M. They must be driven home.

The doctor and nurse give the patients a complete explanation of their postoperative care, including pain, vaginal and incisional bleeding and discharge, sutures, dressings, physical activity, and the time each of these

might be a problem.

At present, a complete description of the operation and its aftereffects is being made up. A copy will be given by the doctor during the patient's visit to the office, so she and her husband will understand and be prepared for the

procedure

This method has proven to be most effective in handling this type of surgery. Of the 1,200 operations completed, only four patients have had to stay in hospital overnight. This was usually because of obesity, when it was necessary to make a larger abdominal incision, or because the patients lived too far away to get home at a convenient hour. — Carol Player, Reg.N., St. Thomas, Ontario.

**CEGEP** graduates

I am writing to inform readers that the first English-language CEGEP nursing students are graduating this June. The French-language graduates have been in the hospitals a couple of years now, and they appear to be coping well—in the English-language hospitals, too.

I am graduating, together with 68 others, from Dawson College in Montreal. Many of us will be working in Quebec. A few will be working outside the province, and I think their education should be known to the hospital

personnel.

We are the first graduates and will be watched closely. However, with our education, we have been taught to watch you closely. So please give us time. We want to learn, and we will, with some patience from you. Accept us as individuals, not as a mass of CEGEP students.

All I ask is that you set a good example of nursing — a good way to help us learn. Maybe we will help you learn something. — Donna Burgess, Montreal, Quebec.

Disappointed in April article

I would like to express my disappointment in some of the articles published in *The Canadian Nurse*, which are vague, generalized, and tell the reader little.

An example of such an article was "Weekend Program for Tubal Ligation" (April 1973). The author was not only vague, but gave many unnecessary details. The fact that the patient's youngest child was watching "Sesame Street" or that the patient was scrubbing the floor is irrelevant. This space could have been used to give more vital information on this subject.

The statement "The nurse next explained...the sequence of events that would take place...recovery room" (page 38) says little. Would readers not also benefit from knowing the sequence of events in the Grace General Hospital? They may be quite different from those in other hospitals.

"Ms. P. wanted to know when she could resume her normal household duties...." and "when she and her husband might resume their marital relations." This, too, is vital information for all nurses, but many do not know the answers because they do not work in such a unit or because they

have not nursed for several years. *The Canadian Nurse* is the medium through which such information should be available.

Some articles can be improved and must be improved so that the nursing profession gains as much as possible from its national magazine. — R.N., New Brunswick (name withheld on request).

### Nurses in Yukon should unite

Registered nurses at Whitehorse General Hospital — a federal hospital — are appalled at the discrepancy in salaries among registered nurses, certified nursing aides, and nursing orderlies. We do not resent the recent salary increase gained by the two latter groups, but we resent the Professional Institute of Canada's lack of response to our concern.

Local supermarket cashiers make approximately \$1.25 an hour more than registered nurses. We believe our pay should be higher because of educational level and responsibility. At present, our contract is under arbitration, but if precedent is any guide, we see no hope of achieving the salary increase we desire.

The rest of the federally appointed nursing groups across Canada generally appear, due to lack of response, to be willing to remain in their present fi-

nancial situation.

As stated by Dr. H.O. Mauksch in The Nurse: A Study in Role Perception, University of Chicago, 1960: "Historically and traditionally, nurses have not tended to engage in collective action, nor have they, as a group, demonstrated assertiveness."

It is time for federal nurses to unite and assert themselves as a group. We would like all federally appointed nurses or interested supporters to write to us with comments and suggestions. We will answer all responses. — C.N. Boyko, 308A Hawkins St., Whitehorse Yukon.

More comments on registration

I support the letter written by Elisabeth J. Storey of Halifax, Nova Scotia, concerning registration in Canada (Letters, March 1973, p. 4). I, too, was originally registered in England and am now married to a member of the Canadian Armed Forces, which means I can look

# Let more effective patient care start with us.

### WATSON: Medical-Surgical Nursing and Related Physiology

The physiologic basis of patient care is discussed in the 27 clearly-written and concise chapters found in this exceptional text. The author reviews the relevant anatomy, physiology, and pathophysiology—and, on that basis, sets forth the rationale and goals of effective treatment and nursing care. Extensive cross-references lead the reader to relevant ancillary discussions. The nearly 100 illustrations are of unusual instructional quality and visual appeal. By Jeannette E. Watson, R.N., M.Sc.N. 786 pp. Illustd. \$10.30. April 1972.

# IRVING: Basic Psychiatric Nursing

Details duties, responsibilities and types of care—with special emphasis on the therapeutic, personalized, comprehensive, preventive, and rehabilitative aspects of effective patient care. Mental illness is described in terms of abnormal reactions to stress. Included are chapters on schizophrenia, manic-depressive illness, senile psychosis, the neuroses and psychosomatic illness. By Susan Irving, R.N., M.S. 319 pp. Soft Cover. \$5.10. January 1973.

### GILLIES & ALYN: Saunders Tests for Self-Evaluation of Nursing Competence

An easy and reliable volume for review and examination of nursing methods, professional skills and medical facts. Presents a collection of representative clinical situations, each with a series of multiple choice questions to test the reader's recall of facts and her ability to apply those facts to the resolution of actual problems encountered in practice. By Dee Ann Gillies, R.N., Ed.D. and Irene B. Alyn, R.N., Ph.D. 392 pp. plus 152 answer sheets. \$7.75. January 1973.

### BERMOSK & CORSINI: Critical Incidents in Nursing

Illuminates common human-relations problems which confront today's nurse. From euthanasia to a professional disagreement with a doctor, each of 38 Incidents is scrutinized by a panel of specialists who voice their opinions on how to approach the problem ethically and with professionalism. Provides a beneficial and exciting learning experience for any nurse. By Loretta Sue Bermosk, R.N., M.Litt.; and Raymond J. Corsini, Ph.D. About 380 pp. About \$12.10. June 1973.

### FREEMAN: Community Health Nursing Practice

Here's a text that prepares the nurse to meet the complex challenge of today's community health practice. The author introduces modern community health nursing as a dynamic and societally-oriented discipline. She presents and discusses the purpose and goals of nursing in community health, the organization and administration of community health services, and the role of the community health nurse in different situations. By Ruth B. Freeman, R.N., Ed.D. 414 pp. Illustd \$7.75. August 1970.

### MILLER & KEANE: Encyclopedia and Dictionary of Medicine and Nursing

The first, all-new nursing encyclopedia in 20 years—a comprehensive reference of accurate, up-to-date information. Clear-cut definitions fill more than 1000 pages. Full-drug data is included. Special sections detail nursing care for most diseases, conditions, and operations—and first-ald instruction for such emergencies as burns, electric shock, and barbiturate poisoning. Contains 122 Illustrations plus 16 pages of full-color plates. By Banjamin F. Miller, M.D., and Claire B. Keane, R.N., B.S. 1089 pp. 122 ills. + 16 full-color plates. \$9.95. March 1972.

833 Oxford Street, Toronto 18, Ontario	Y CANADA, LID.			
Please send and  bill me  check enclosed—send postpain 9135 Watson: Medical-Surgical Nursing \$10.30. 1696 Bermosk & Corsini: Critical Incidents About \$12.10. 5045 Irving: Psychiatric Nursing \$5.10.	☐ 3876 Freeman: Community Health Nursing \$7.75.			
NameAddress				
	CN 7-73			

### letters

(Continued from page 4)

forward to changing provinces fairly

frequently.

Having struggled with one province for five months, by letter across the Atlantic, trying to prove I had done what my certificates must surely prove, I now face another move after only one year. This time it will be even harder, as this particular province has a ruling that anybody coming in from outside must rewrite RN exams, no matter what.

I have now had eight years postgraduate experience and feel humiliated and enraged that I should have to go through this process yet again. It's enough to have to battle for months on end for one's papers to be evaluated, without having to rewrite examinations, which I had hoped I'd finished years

Isn't it time Canada had one national paper or standard that allowed "vagrants" like myself (and many more like me) to wander freely across its wastes? Even if provincial papers remained, it ought surely to be possible to obtain a "national certificate in nursing.'

Like Ms. Storey, I wonder just how long my manuscripts will be kept in England and how many more times I will need to write overseas. — Jane Robichaud, S.R.N., S.C.M., O.N.C.

Categorizes books for nurses

You have published a series of letters concerning the merits of one specific text. I would like to generalize on the topic of texts for nurses. In writing book reviews, preparing reading lists, and reading student papers, I find myself categorizing the books available to nurses.

There are those texts written by the nurse specialists who use the best upto-date resources from all fields. These, for the most part, are excellent. Occasionally the style is cumbersome, but the content is up-to-date.

Then there are the texts written for nurses by other professionals who believe they know nursing's needs. These books range from excellent expositions to oversimplified condensations. Evidently, the market for nursing books is large, and many are trying to get onto the bandwagon.

There are those who think so little of the discipline of nursing that they offer nurses a nondocumented, oversimplified text with no bibliography or further reading lists. One does not learn to discriminate by being presented with large amounts of poor material.

Yet it is from this watered-down material, so readily available, that many nurse authors choose to draw their information for a third category of texts, namely those written for nurses by nurses using material from these oversimplified books.

This to me is the most disturbing group, as we see the weaknesses of the second category compounded. Not enough nurses, Canadian nurses especially, are writing books, and we should commend those that do. But when they are hampered by the condescending resource material available, it is no wonder the quality of books is ques-

What should be done about this? One drastic but positive action would be to look at our libraries and weed out texts not up-to-date or not of the caliber we would like. Let us provide only books that stimulate an individual to discover, to read further, even to use the recent journal literature — and not just in nursing.

Another way is to protest by not buying these books. A word to the publishers' agents should also help. One can also protest by critical reviewing — the fact that a book is written for nurses does not necessarily mean it

should be read by them.

Nursing must not be satisfied with anything but the best, for a profession is judged, at least in part, by the quality of its literature. — Jo-Ann Tippett Fox, R.N., M.Sc., Assistant Professor, Dalhousie University School of Nursing, Halifax; Nova Scotia.

Students gain experience

Third-year nursing students at Queen's University in Kingston, Ontario, are gaining broader knowledge and prac-

tice in maternity nursing.

In January 1973, each student was assigned to an expectant mother in the community who was willing to participate in the program and whose delivery was expected in February or March.

We visited the home to teach methods of relaxation, breathing control, and muscle toning, and to discuss aspects of baby care. After assessing the home situation, our purpose was to help the mother and father-to-be with their approaching parenthood.

Before each subsequent visit, we formulated a teaching plan outlining our objectives for that visit. After we submitted the plan to an advisor for review and discussion, we made the visit, then modified and evaluated the plan. When we needed help in specialized areas, we had access to a nutritionist, social worker, and psychiatric specialist on the nursing faculty.

During our visits, we formed close relationships with "our mothers," and involved the husbands as often as possible.

With the onset of labor, we met the mother in the hospital and stayed with her during labor, delivery, and the immediate postpartum period. We monitored the progress of the labor and reported this to the staff at necessary times. A faculty instructor was always present or on call.

Many mothers said that having with them someone they trusted and could confide in helped tremendously. We shared the joy of birth with them and cared for the baby until transfer to the nursery. We also attended to the mother during the initial postpartum

period.

Helping to cope with minor crises that can occur when the mother arrives home is important to the family's adjustment. We helped by reassuring the mother, answering her questions, and encouraging her efforts to deal with the baby. We assessed the baby and observed his behavior. Our purpose was to improve the care the parents gave their child.

This experience enabled us to analyze the various aspects of nursing involved in meeting all of the mother's requirements. By sharing our experiences, we learned how each labor and delivery is different, and each one

normal for that mother.

The families have expressed many positive feelings. None of us will forget the important aspects of maternal and child health nursing we learned. As graduates, we will be more aware of the total patient and her needs. — Janet P. Cross, Ottawa, Ontario.

Agrees with May letter

My eye was particularly caught by the letter to the editor, "Compares Canada to the Philippines," in the May issue

(page 4).

Three cheers for Ms. Heber. I agree wholeheartedly with her. In the Halifax area, a registered nurse faces the responsibility of being in charge, of giving medications, and of running her unit smoothly for eight hours, as well as giving IVs, following doctors' orders, and so on. She also sterilizes bedpans and straightens the soiled utility room with the certified nursing assistant.

There is a definite need to know where the duties of the CNA cease and those of the RN begin. I don't know too many RNs who find the time in their eight hours on duty to use their brains. The feet and hands, not the head, suffer from overwork. - Name withheld on request.

6 THE CANADIAN NURSE

#### news

South Africa Nursing Association Must Try to Change Law by '75:ICN

Mexico City, Mexico — A resolution passed by ICN's governing body May 12 "requests the South Africa Nursing Association to take action to enable nonwhite members of SANA to serve on the board of directors" no later than January 1, 1975.

The resolution of the Council of National Representatives (CNR), which met in closed session before the ICN Congress opened May 13, further states that if SANA fails to comply with this request, the ICN board of directors will recommend to the CNR at its 1975 meeting that SANA be expelled from the international organization.

At a press conference Monday morning, May 13, ICN president Margrethe Kruse explained that the South African question was brought forward by the Swedish Nurses Association in relation to a policy statement the CNR adopted in Dublin in 1971. In that statement, CNR endorsed the United Nations document on the declaration of human rights.

Ms. Kruse noted that South Africa voted in favor of this endorsement, which included an obligation on the part of all national associations to take steps to implement the principles involved in the declaration.

In considering this question, Ms. Kruse said, the ICN board of directors had a dialogue with the president of SANA, Dr. Charlotte Searle, to get as much information as possible about the situation in South Africa, to give the CNR.

"It was obvious that SANA had made great efforts to improve the educational standards of nonwhite nurses and also to narrowing the gap in conditions of work between nonwhite and white nurses" said Ms. Kruse

nurses," said Ms. Kruse.

"Nevertheless," she added, in the South African nursing act, which also includes the regulations of SANA, "there are discriminatory clauses that prevent the colored and Bantu nurses from being elected to the board of directors of SANA." (These nonwhite nurses elect a white nurse to represent them on the SANA board.)

Ms. Kruse said, "CNR decided with an overwhelming majority to request SANA to take action to have this decision changed in the nursing act before January 1, 1975."

She pointed out that because the board of directors of SANA is the governing body of the association, all the powers of the association are vested in the board. Thus it is not a question of personal status, she said, but a question of being involved in the policy and decision making of the association.

"It is therefore of the utmost importance for Bantu and colored nurses to ... elect one of their own people to this board."

The ICN president emphasized: "SANA is a strong association, and it is ICN's hope that the association's strength will prove its value and that SANA will be able to comply with the request of ICN."

There are over 28,000 members of SANA — the sixth largest ICN member association. It joined ICN in 1922.

SANA's president told the ICN board of directors that the number of non-white nurses in South Africa has increased from 546 in 1948 to 17,537 at the end of 1972. According to Dr. Searle, this resulted from "sustained pressure on the State Department and on educational authorities by the board of SANA."

The opportunities for the professional development of nonwhite nurses and the professional benefits they have gained through SANA's efforts, Dr. Searle told the ICN board, "are superior in many respects to those which exist in many Western countries and, with few exceptions, are already in every respect on a par with that obtained for white nurses in South Africa.

"These exceptions have for a long time been the subject of negotiations with the authorities, and it's gratifying to note that as the financial situation of the country improves and as certain national units are moving toward political independence, the disabilities referred to are being reduced."

In her report to the CNR in Mexico, Ms. Kruse pointed out that ICN was suspended from UNESCO December 31, 1971, after an investigation of all non-governmental organizations with branches or affiliates in South Africa.

However, on the basis of SANA's endorsement of the U.N. Declaration of Human Rights at the CNR meeting, in 1971, ICN's suspension was rescinded in June 1972.

**CPHA Delegates Adopt Policy Opposing Fee-For-Service** 

Montreal— "Fee-for-service" payments were a major topic of discussion at the Canadian Public Health Association annual meeting in Montreal April 24-27, with the CPHA adopting a policy paper opposing fee-for-service as "outmoded," and several speakers saying the method encourages abuses.

"The present fee-for-service method of payment is outmoded and forms a serious barrier to future evolution of Canada's health service system," the association said in a policy paper passed by delegates and approved in principle by the CPHA council.

"What must be emphasized... is that the method of payment, not the level of payment for professional services, is a critical issue in the future evolution of our health care system. The development of a real, cooperative, and functional health care team will not be possible with the fee-for-service payment for physicians."

Speakers Robin Badgley, sociologist and head of the behavioral science department at the University of Toronto, and Dr. Samuel Wolfe, a former physician and commissioner in Saskatchewan when medical care insurance was introduced and now professor of medicine at Meharry Medical College in Nashville, Tenn., went even further.

Fee-for-service payments have encouraged abuses of the medical care insurance program and raised health care costs, they told the meeting. It encourages doctors to plan for unnecessary visits by patients and probably even to some unnecessary surgical procedures, they said.

"Under the fee system...there is every incentive to try and admit patients to hospital, to keep them in hospital a little longer than may be necessary, and to perform major surgery."

The association also passed policy statements, in principle, stating that improvements in health care are linked to the ability of health professionals to function together in a multidisciplinary team.

The statement, which contained 16 separate statements of belief, said, "The concept of the nurse practitioner, who, as a member of the multidisciplinary health team will function in an

expanded role in providing primary health care, is a valid application of the adaptation of an established health profession." It also said the traditional concept that the doctor is the team leader must be abandoned.

About 550 delegates registered for the conference. All provinces were

represented.

The meeting also approved policy statements on quality of health care, on regionalization of health services in an integrated system, and on environ-

mental health policy.

The council's closed sessions also were told that the association is facing financial difficulties "within three years," unless it can attract more members. Membership in the 2,500-member association is open to the public.

RNAO Supports Central Union To Replace Bargaining Units

Toronto — Voting delegates at the Registered Nurses' Association of Ontario (RNAO) annual meeting unanimously supported the establishment of a central vehicle for collective bargaining for nurses by nurses. The resolution endorsed the formation of a central union by the Nurses' Central Security Fund (NCSF) and offered the NCSF "every possible assistance in the achievement of this goal" of centralized collective bargaining.

According to the resolution, RNAO will provide necessary services, on a contractual basis, to the new central union and will maintain an employment relations department to serve all

RNAO members.

The resolution came up for discussion on the first afternoon of the annual meeting, May 3, but voting was postponed until the final day, May 5.

Dr. Josephine Flaherty, RNAO president from 1971 to 1973, said there is urgent need for a centralized body. There are now 91 separate collective bargaining units of nurses in Ontario, most with one-year contracts; each of the units has chosen to ask RNAO to serve them.

RNAO cannot continue to serve the mushrooming units, Dr. Flaherty said; nurses cannot continue to bargain in individual units and achieve their goals.

The RNAO, in its present form, cannot become certified as the central bargaining agent. Graduate non-registered nurses are members of the individual bargaining units but not of RNAO. It was the overwhelming deci-

It Gives A Lovely Light!



The mortgage for nearly \$400,000, taken out in 1956, on the RNAO building at 33 Price Street, Toronto, was paid up two years ahead of time. The mortgage was burned in a happy ccremony during the RNAO's 48th annual meeting in May. Dr. Josephine Flaherty, *left*, held the burning paper up, watched by a large number of RNAO convention attenders and invited guests. On the platform with her were, *left to right*, Florence Walker and Alma Reid, RNAO executive secretary and president who signed the original mortgage, and Wendy Gerhard, Registered Nurses' Association of Ontario president for 1973-75.

sion of RNAO directors not to change association structure to allow membership to nonregistered nurses.

Problems Of Teachers, Students Discussed At RNAO Meeting

Toronto — Voting delegates and members of the Registered Nurses' Association of Ontario (RNAO) discussed problems of nurse-teachers in being classified for jobs in community colleges and problems of interesting students in the association.

A resolution, approved on Saturday, May 5, asked that RNAO be recognized as the official representative of nurse-teachers until they have joined the faculties of community colleges and become full members of the union representing Ontario civil servants, including community college faculty members.

All diploma nursing programs in Ontario will become part of the community college system on September 1, 1973. (News, March 1973, page 14.) The Ontario minister of colleges and universities, Jack McNie, bringing greetings to the RNAO at the opening session, said: "... over the past two

weeks there has been concern about the classification of (nurse) faculty as they move into the college system. . . . We had hoped that by delaying the actual classification discussions for perhaps a month or six weeks, we could have it done under the new classification system which has been under development in the colleges for two years and will be effective this September. It would have simplified the work involved if it could have been done only once.

"However, we recognize the uncertainty this has created, and are now encouraging task forces and colleges to proceed to classify faculty under the present system," Mr. McNie said. "This, in fairness to those who wish to transfer, gives them the best possible information on which to base their decisions."

Voting delegates approved a resolution that the RNAO support the concept that all registered nurses, on initial employment as an RN, receive the same basic starting rate of salary within an employing agency, with appropriate recognition for education.

Having supported the idea of equal pay, the delegates defeated two reso-

lutions ealling for a reduced membership fee for new graduates and a special student membership. More than 200 students attended the annual meeting and several spoke to support the resolutions that would give students and new graduates the benefits of RNAO membership at reduced cost.

During discussion of the transfer of diploma nursing programs to the community colleges, one student said: "Students are concerned. You've jacked up the prices (Ontario diploma students paid tuition and residence fees for the first time in 1972-73) and changed the school. We're for you, but we'd like to know what's going on."

**New Board and Committee Elected at ICN Congress** 

Mexico City, Mexico - In the constitution of the International Council of Nurses, amended during the ICN Congress in May, there is now one standing committee instead of two. The professional services committee remains. ICN's board of directors will carry out the functions of the former membership committee.

Before the Council of National Representatives voted for the new board and committee members May 17, ICN president Margrethe Kruse suggested an enabling motion "that CNR refrain from voting on any candidate for the membership committee."

This motion, which was carried, was necessary because the constitution requiring two standing committees was in effect until the end of the 15th quadrennial congress.

Those elected to the seven-member professional services committee for the 1973-77 quadrennium are:

Rebecea Bergman, head of the nursing department at Tel Aviv University in Israel and a member of this ICN committee for the past four years, chairman for 1973-77;

Hermosinda de Campos, chief nursing supervisor for Esso in Tartagal, Argentina, and a member of the special committee to consider the study of ICN objectives, structure, and functions, 1971-73:

Isabel C.S. Brown, chief nursing officer, King's College Hospital Group, London, England:

Ayodele Akiwumi, president of the Ghana Registered Nurses' Association and lecturer in medical-surgical nursing and curriculum development for the schools of nursing, University of Ghana;

Birthe Kofoed-Hansen, director of the Bispebjerg School of Nursing in Copenhagen, Denmark;

Elisabeth Stussi, instructor at the International School for Post-Basic

Nursing Education, Lyons, France;

Jessie M. Scott, assistant surgeon general, United States Public Health Service; and director, division of nursing, National Institutes of Health, department of health, education and welfare, Washington, D.C.

Among the II nurses elected to ICN's board of directors is Nicole Du Mouchel, Montreal, executive director and secretary registrar of the Association of Nurses of the Province of Que-

The other new board members are Ingrid Hämelin, Finland; Fumie Kobayashi, Japan; Hildegard E. Peplau, USA; Barbara N. Fawkes, England; Elouise C. Duncan, Liberia; Olive Eva Anstey, Australia; Hamuda Mar-Haim, Israel; Mary Jane Seivwright, Jamaica; Jadwiga Izyeka, Poland; and Maria Eleftheriou, Greece.

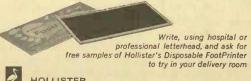
For information about new ICN president Dorothy Cornelius, USA and the three vice-presidents, see Names, page 16.



## instant prints without

## disposable FOOTPRINTER

Now you can get perfect footprints of the newborn more easily then ever before. Hollister's Disposable FootPrinter contains just the right amount of Ready-Rolled® Ink for two baby footprints and a correlating print of the mother's thumb or finger. To use, lift from dispenser box, apply to skin, make your print, and dispose of the FootPrinter. You get good prints fast-without the mess of old-fashioned ink-and-roller methods.



HOLLISTER

HOLLISTER LTD., 332 CONSUMERS ROAD, WILLOWDALE, ONT. IN CANADA, HOLLISTER LIMITED



#### news

#### CNA Pres.-Elect Tells RNAO Society Needs Coping Resources

Toronto — Huguette Labelle, president-elect of the Canadian Nurses' Association, told a luncheon audience at the RNAO annual meeting, May 5: "I doubt whether we will reach 'sociostasis.' Society will continue to need re-

sources for coping.'

Ms. Labelle, principal nursing officer, Health and Welfare Canada, said she is concerned about high-rise living. Individuals work in a cubicle called an office, ride home in a cubicle called a car, and live in a cubicle called an apartment. "In what way can we (nurses) influence community councils to get more greenery, indoor and outdoor space for physical activity, space for health services and day care centers in high-rise apartments?" she asked.

She expressed concern for the personality and development of children raised where there is no space for socializing or for physical development. "Because of lack of early detection, deterioration of the child and of his family often requires extensive treat-

ment."

"Are we as nurses militant in assuring that the institutionalized aged receive health care?" she asked. None of us is involved in all social issues, she said, but some of us will be involved in some. Involvement is our choice.

"The degree of day-to-day activity in issues of our time as individuals, as citizens, as a collective profession, is the measure of where we stand on the continuum of amateurism-profession-

alism," Ms. Labelle said.

RNAO Told Confusion Of Goals Prevents Nursing Communication

Toronto — "No one is served — not patients, not nursing practitioners, not nursing service administrators, and not nursing educators — in a system where confusion of goals has jammed the lines of communication so that all we hear from each other is noise," Myra E. Levine told nearly 1,500 registered nurses and nursing students at the annual meeting of the Registered Nurses' Association of Ontario on May 4. Ms. Levine is associate professor of nursing

**ICN Report** 

A report of the International Congress of Nurses, held in Mexico City, May 13 to 19, will appear in August.

at Loyola University, Chicago.

Ms. Levine said nurses have been taught to guard against all the things that could harm a patient but "we have not been taught to search out, cherish and sustain the dignity and humanity that marks him as human being."

Speaking about the danger of a token role for the consumer in decision making, Ms. Levine said: "... The tokenism of an outvoted position on a committee may result in a quieter public but it will not provide a better system of health care."

Nursing is an intensely personal form of human experience, Ms. Levine said. "The most sophisticated technology, the most esoteric science avail us nothing if, in using them, we fail to use the spirit... of our very imperfect humanity. We must stop confronting each other and begin to confront the issues we all share as members of a community.... We will cherish ourselves when we have learned to cherish our patients. Out of their sustained humanity, we will discover our own."

CNA Gets Ready For The Day When Canada Goes Metric

Ottawa—"Implementation of the change to the metric system on a national scale is imminent, but the change will take place over a period of ten years or so," Jane Henderson, associate executive director of the Canadian Nurses' Association, told *The Canadian Nurse*. She represents CNA on one of the steering committees set up by the Metric Commission of Canada.

"Because of the number of nurses and their wide contacts, in addition to most being women and all being consumers, nurses as a group are regarded by the Metric Commission as one of the most important influencers of the public in conversion to the metric sys-

tem," she said.

CNA is setting up an advisory committee, made up of representatives of each provincial association, to provide information to help the Metric Commission in deciding mechanisms of the change.

"Nurses will be seeing signs of conversion very soon, in their daily lives as well as in their places of work," she

said.

CNA's representative suggested that nurses, in preparation for the change to metrics, should:

• Push for inservice programs in their

places of work;

• Begin to think metric about the common things of life; volumes and weights of grocery products are or will soon will be marked in metric values, liters and grams; bra and shirt sizes will be in centimeters;

• Purchase new household items, such as bathroom scales or indoor-outdoor thermometers, in metric values.

"A weight watcher takes longer to lose a kilogram than a pound," she said, "but he doesn't gain one as quickly, either."

Children in primary school are or will soon be taught math in metrics, so parents will need to understand the system. But, some older people will be unable to make the transition, judging from experience in Australia where the conversion is well advanced.

Nurses should be careful to have conversion tables verified by the Metric Commission, before adopting them. This can be done through CNA, or by writing directly to Metric Commission, 320 Queen St., Ottawa K1A 0H5.

"Mediscope" Launched

Montreal — Dr. Gustave Gingras, president of the Canadian Medical Association, was host at the launching of the new CMA publication Mediscope, a newspaper for the Canadian health care team.

The University Club in Montreal was the setting for the May 30 gathering of representatives of the medical profession, the major drug companies, and several para-medical disciplines.

The "Scope," according to Dr. Gingras, is meant to bridge the communication gap among the various members of the health care team and will be devoted to issues that are either common to, or affect, several disciplines. Particular attention will be given to the larger issues of health care economics, medical-political affairs, the provision of health care, professional activities, and viewpoints that may have significance for other members of the team.

Starting with the first issue September 1, 1973, *Mediscope* will appear monthly until January, 1974, when it becomes a semi-monthly publication. Of its sixteen pages, eight will be devoted to text, and eight to paid adver-

tising.

Initially, its distribution will be to the entire medical and pharmaceutical fraternity and, through the courtesy of the chief of the medical staff, to medical and hospital administrators, physiotherapists, radiology and laboratory technicians, medical education

Countdown 1972

Countdown 1972, a book of Canadian nursing statistics, has recently been published by the Canadian Nurses' Association. Copies are \$5.50 and may be ordered from CNA House, 50 The Driveway, Ottawa, Ont. K2P 1E2. Please include payment with the order.

and administrative personnel, and senior nursing administrators and teachers. Subscriptions will also be available.

Editorial director of Mediscope is D.A. Geekie; editor, M. Koreok; assistant editor, J. Garner. Editorial offices will be at CMA's headquarters in Ottawa, Ontario.

Dr. Gingras describes this venture as a communications research project

with an immense potential.

Milan Korcok, noted medical journalist, finds it a particularly exciting prospect, in that the aim of the CMA in publishing Mediscope is to seek to promote sound understanding of current issues among those professions that must ultimately meet the public's demands for health care — physicians, nurses, dentists, pharmaeists, and other allied health workers. He adds, the term "teamwork" has been an artifact long enough.

Teachers' Brief To Government **Urges Revision In Copyright Act** 

Ottawa — A key recommendation in a brief submitted by the Canadian Teachers' Federation (CTF) to the prime minister and federal government in March urges that revision of the Copyright Act not be delayed and that anyone interested should have the chance to participate in the revision.

CTF explains that the provisions of the Copyright Act are of major concern to teachers in two ways: they affect the availability of teaching and learning materials, both print and nonprint, and they affect the interests of teachers as participants in the production of educational materials.

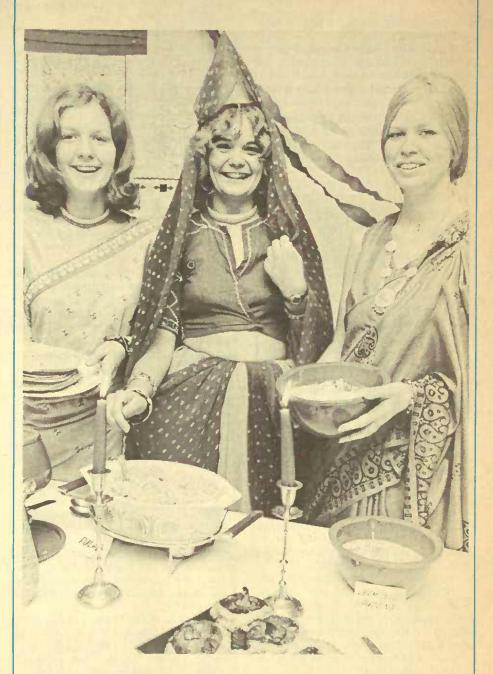
Another key recommendation calls for creation of a Canadian Office of Education, supported jointly by the federal, provincial, and territorial governments. CTF says this office would be responsible for collecting, organizing, and disseminating information to provincial and territorial government authorities; promoting and supporting an adequate program of research in education; over-seeing a continuous study of the fiscal problems affecting education; and consulting with provincial governments in solving these problems.

According to the federation, "wastage" and overlapping that occur with a number of federal government departments involved in education would be cut down if a federal office of education coordinated educational activities.

Other recommendations in the CTF brief eall for:

• Creation of appropriate bodies to advise on national policy respecting production, distribution, and use of educational media, with Canadian

#### **Exotic Foods Part Of Course For Nursing Students**



In November 1972, the first-year nursing class at Owen Sound Regional School of Nursing in Owen Sound, Ontario, sampled some of the ethnic differences in multicultural Canadian society. The students shown here are, left to right, C. Simpson, C. Paquin, and S. McLachlan. Although emphasis was on dietary practices, other aspects of daily living were highlighted through a project designed by the teachers. The class, divided into six groups of some 15 students each, chose to study China, Germany, Greece, Holland, India, and the U.S.S.R. Students wore authentic national costumes and displayed artifacts of esthetic interest and of daily use. Posters, pictures, and other items decorated the walls, and national music added to the atmosphere. In adjoining cafés, students served guests samples of several dishes from each country; they used traditional utensils and provided recipes. This project allowed the students to offer hospitality to friends, staff from nine participating hospitals, and members of the board of governors. Director of the school is Edith Bell.

#### news

teachers having direct representation on these bodies.

 Amendment of the Canada Pension Plan to lower the age of eligibility for retirement pension to 60, which would be in the interest of Canadian society and the national economy.

A delegation from the CTF discussed the brief with Secretary of State Hugh Faulkner March 12, and expects to hold further meetings with cabinet ministers.

Start From Where You Are **Directors Of Nursing Told** 

Halifax, N.S. — "Unless you start from where you are, you'll never arrive,' Norma Wylie, director of nursing at McMaster University Medical Centre, told 30 directors of nursing from hospitals throughout Nova Scotia. The directors were attending the workshop she directed in Halifax, May 3-4, 1973.

Ms. Wylie spoke about the many changes there had been in nursing in the last 30 years and reiterated the prediction that there would be more changes in the next 30 years than in the last 100.

Because of the many demands being made on nursing service, the directors had met to discuss ways to meet these demands. The theme of the workshop was "The Role of the Nursing Service Administrator in 1973." It was organized by the directors of nursing in the Halifax-Dartmouth area in cooperation with Jean MacLean, nursing service consultant of the Registered Nurses' Association of Nova Scotia.

Some of the topics covered were continuity of care in the hospital, coordination of care in the hospital and community, helping nursing personnel to develop, initiating change within the limitations of the physical and social structure of a hospital, and effective use of time.

#### Wage Settlement in Alberta **Averts Nurses' Strike**

Edmonton, Alta. - Nurses in the bargaining unit at the 976-bed Royal Alexandra Hospital were prepared to strike in May, rather than accept a conciliation board award. However, they were relieved when a last-minute settlement with the hospital board, which is expected to become the bench mark for nurses' wage and salary agreements in the province, was worked out.

The 628 nurses in the hospital bargaining unit received a salary increase

of 21 percent over two years on a basic salary of \$550 per month. New benefits also included a shift differential of \$1.25 per afternoon and evening shift and a reduction in the

working day to 73/4 hours.

Salary ranges for general duty staff nurses, as of January 1, 1973, are \$605 to \$760 per month; as of August 1, 1973, they are \$625 to \$785 per month; and as of January 1, 1974, \$665 to \$830 per month. Differences in pay were "maintained between staff nurses, assistant head nurses and head nurses, and instructors.

This settlement was the first in the 1973 round of bargaining for nurses in Alberta. At the time of the settlement, group bargaining between the Alberta Association of Registered Nurses and the Alberta Hospital Association, which represents 51 other hospitals, had only reached the conciliation board hearing stage.

According to the AARN, this was also an important settlement because it clearly showed the results of a positive plan of action by the nurses. At the time of the settlement, the nurses' group had completed the final plans for action during the strike, which would have been legal.

To prepare for a withdrawal of

services, the nurses' group formed committees that involved more than 150 nurses. These ranged from a fivemember strike benefits committee to a 30-member telephone information committee.

A strike headquarters, which had been leased, was to be the administrative center for all the activities, including the operation of an emergency services plan. A public information campaign, designed to reflect the group's integrity and professionalism, was also planned.

The provincial government's industrial relations board was instrumental in bringing both parties back to the bargaining table. The nurses had rejected a conciliation board award that gave them a 14 percent increase over two years. They were aiming at a salary of \$625 per month — midway between Saskatchewan nurses' \$580 and British Columbia nurses' \$670.

It was after a supervised strike vote, in which 583 nurses indicated their willingness to use the ultimate sanction, that the industrial relations board began working to bring the two sides together. Yvonne Chapman, AARN employment relations officer, represented the nurses on behalf of the staff nurses' association's negotiating committee.

#### **Next ICN Congress in Japan**

The Japanese Nurses' Association will host the 1977 ICN Congress — the first to be held in Asia.

At the ICN Congress in Mexico City in May, representatives from Japan, Israel, and Nigeria extended invitations to hold the next ICN quadrennial congress in their countries. When the votes by the members of the Council of National Representatives were counted, Japan received 30, Israel received 21, and Nigeria received 11.

Hamuda Mar-Haim, president of the National Association of Nurses in Israel, invited ICN to hold its next congress in her "ancient, new country" and the holy land to many religions.

Kofoworola Abeni Pratt, president of The Professional Association of Trained Nurses of Nigeria, said in extending her invitation that Nigeria is typical of the developing countries. She urged that nurses from the developed countries see the health problems in her country.

Fumie Kobayaski, president of the 42,300-member Japanese Nurses Association, spoke of the earnest desire of all members of the association to host the next ICN Congress, which she noted had never been held in Asia,

#### RNAO Accepts Statement On Role And Functions Of Nurse Midwife

Toronto—A statement on the role and functions of a nurse midwife, prepared by an RNAO working party, was accepted unanimously by voting delegates at the RNAO annual meeting, May 3 to 5.

The role encompasses the total maternity cycle but nowhere does the statement refer to the nurse midwife delivering babies. Mary Cameron said the working party believed the nurse midwife would deliver babies under certain circumstances, but the statement avoids undue emphasis on one aspect of technical care.

The purpose of the statement is to initiate dialogue with other groups; it defines what the RNAO means by

nurse midwife.

The statement says the nurse midwife would be prepared at two levels. the registered nurse with a diploma or baccalaureate in nursing and additional formal preparation in nurse midwifery, who will function in first-level positions; and the registered nurse prepared as a clinical specialist, who has a master's degree with a major emphasis on nurse midwifery, or in a related clinical field, such as maternity nursing, maternal-child nursing, or community nursing, and who, in addition, has formal preparation in nurse midwifery.

### new products {

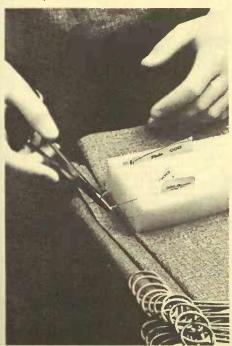
Descriptions are based on information supplied by the manufacturer. No endorsement is intended.

#### Suture holder

Davol Inc. has something new for organizing sutures during surgical procedures. It is a block of flexible foam that is adhesive backed and slit to create four deep slots into which sutures and other surgical implements can be arranged. The holder, supplied sterile in a blister pack, is intended for single patient use.

Various uses for the product include holding ties and sutures of various lengths and sizes, delicate surgical instruments, brain patties, and other small items. It can also serve as a protective dispenser for used needles and scalpel blades following the procedure. The holder can be positioned either on the instrument table, Mayo stand, or attached to the drape at the operative site.

The holder is  $2^{\frac{1}{2}}$  inches wide,  $1^{\frac{1}{2}}$  inches high, and 12 inches long. A 6-inch-long version is also available. For more information, write to Davol Inc., Box D, Providence, Rhode Island 02901, U.S.A.



Suture Holder

#### Lubricant for body rubs

**JULY 1973** 

A soothing lubricant especially designed for hospital body rubs is available from American Hospital Supply, 1076 Lakeshore Road East, Mississauga, Ontario. Amerigold lotion, which is also a refreshing moisturizer for dry hands, contains 25 percent oils (mostly mineral), lanolin derivatives, and silicone. It contains no hexachlorophene. The silicone component of Amerigold acts as a repellent to water-borne irritants.

This lotion contains only the lanolin derivatives, which provide moisturizing agents, supplement natural skin oils, and lubricate the skin. Amerigold has a pleasing fragrance.

#### S.A.S.-500

ICN Canada has announced a new product on the Canadian market: S.A.S.-500 (Salicylazosulfapyridine 500 mg per tablet).

S.A.S.-500 is indicated in the treatment of ulcerative colitis, especially for chronic administration. It is a scored tablet, sold in bottles of 100 and 500. One of its advantages is that the tablets are thinly film-coated to prevent staining and overcome powdering and crumbling, but are still easily broken at the score.

Dosage should be individualized and given frequently in divided doses. Food or milk may minimize possible gastric reactions. S.A.S.-500 is not recommended for children under five years of age. Usual maintenance dose is 2 Gm daily for adults, and 0.5 to 1 Gm for children over five years of age. More information can be obtained from 1CN Canada Ltd., 675 Montée de Liesse, Montreal 377, Quebec.

#### Mobile pulmonary function clinic

A mobile clinic has been developed by Calumet Coach Company, Chicago, to help detect and evaluate respiratory diseases. Designed as a trailer clinic, it contains a pulmonary function laboratory, three interviewing rooms, a reception area with upholstered lounge, an x-ray viewing room, a washroom, and substantial storage facilities.

Features of the mobile clinic include special tank carrying compartments for the necessary test gases, reel-mounted inlet electrical cables, centralized heating and air conditioning, unitized water systems, and high-level lighting.

Complete information is available from Calumet Coach Company, 11575 South Wabash, Chicago, Illinois 60628, U.S.A.

#### Nasogastric feeding tube

Long-term tube feeding of medical and surgical patients unable to swallow spontaneously is possible with a new reusable nasogastric feeding tube, introduced by Health Development Corporation (HEDECO).

The Keofeed Stomach Tube consists of soft silicone rubber tubing weighted at its distal end with a short column of elemental mercury. Perforations next to the mercury permit free passage of food into the stomach.

The soft, resilient silicone rubber, which is essentially nonreactive to body tissues, increases comfort and decreases the likelihood of pressure necrosis of the pharynx or aspiration pneumonia. Thus long-term implacement in the stomach without loss of flexibility is possible. It is especially suitable for the debilitated or fragile

This tube is also suitable for duodenal or jejunal feedings, as it passes readily through gastrostomy tubes installed in gastrectomy or pancreatic surgical patients. It may be reused repeatedly without change in physical properties.

Individually packaged, sterile tubes are available from HEDECO, 2411 Plugas Avenue, Palo Alto, California, 94303, U.S.A.



THE CANADIAN NURSE 13

MRS. R. F. JOHNSON SUPERVISOR CHARLENE HAYNES MRS. HOLBROUN ANN COHN, L.P.N. No. 510 Vame Pins 'n Things...from Reeves

#### IT'S EASY TO ORDER REEVES NAME PINS FOR YOURSELF OR FRIENDS!

Choose style you want, shown left. Print name (and 2nd line if desired) on dotted lines below. Check other info in boxes on chart, clip this section and attach to couper

bottom left. Attach extra sheet for additional pins. NOTE SAVINGS ON 2 IDENTICAL PINS . . . mare convenient, spare in case of loss.

2nd LINE: BACAGROUMD COLON (Plastic) PRICES\* Engraved 1 Line | Engraved 2 Lines ALL METAL . . . rich, trim and tailored. Lightweight, smooth edges, rounded corners. Does ☐ Gold ☐ 1 Pin 1.98 ☐ 1 Pin 2.58 169 ☐ Silver PLASTIC LAMINATE . . . slimmer proader; engraved thru surface to contrasting core color. Seveled porder matches lettering. LASTIC LAMINATE Black Dk. 8lue ☐ White .95 1 Pin 1.45 Med. Green Med. Slue Cocoa 2 Pins 1.65 2 Pins 2.30 559 METAL FRAMEO ☐ Gold ☐ Silve ☐ 8lack ☐ Dk. 8lu 100 only OLDED PLASTIC .. ☐ 1 Pin .95 ☐ 1 Pin 1.45 ☐ 2 Pins 1.65 ☐ 2 Pins 2.30

QUANTITY DISCOUNTS: 10-24 pins, deduct 10%; \*Please add 25¢ per order for 3 pins or less. 25-99 pins. 15%: 100 or more pins. 20% --------------------------



SCOPE SACK neatly carries and protects Nursescope or any scope. Double-thick frosted flexible plastic, white vinyl binding. 4½" x 9½". Your own initials help prevent loss. No. 223 Sack...1.00 ea. 6 or mere 75¢ ea. Your initials gold-stamped, add 50¢ per sack.

#### NURSES PERSONALIZED ANEROID SPHYG.

ANCROUD SPHTG.

A superb instrument especially designed for nurses! Imported from precision craftsmen in W. Germany. Easy-to-attach Velorco cuff, lightweight, compact, fits into soft sim. leather zippered case 25½" x4" x7". Die Calibrated to 320 mm., Dieyar accuracy guaranteed to 23 mm. Serviced by Reeves if ever required. Your initials engraved on manometer and gold stamped on case FREE, for permanent identification and distinction. A wise investment for a lifetime of dependable service!

No. 106 Sphyg. ... 32.95 ea. No. 106 Sphyg. . . . 32.95 ea.



#### CAP ACCESSORIES

(NAI) CAP TOTE keeps your caps crisp and clean while stored or carried. Flexible clear plastic, white trim, zipper, carrying strap, hang loop. Stores flat. Also for wiglets, curlers, etc. 8½" dla., 6" high.

No. 333 Tote... 2.65 ea., 6 or more... 2.35 ea. Your Initials gold-stamped, add 50¢ per Tote.



WHITE CAP CLIPS Noids caps firmly in place! Hard-to-find white bobbie pins, enamel en fine spring steel. Eight 2" and eight 3" clips included in plastic snap box. No. 529 Clips . . 3 boxes for 1.95, 6 for 3.25, 12 for 49¢ ea.

#### MOLDED CAP TACS

Replace cap band instantly. Tiny plastic tac, dainty caduceus. Choose Black, Blue, White or Crystal with Geld Caduceus; or all Black (plain). The neater way to fasten bands. No. 200 Set of 6 Tacs . . . 1.25 per set. 12 or more sets 1.00 per set



RN

Send to

METAL CAP TACS Pair of dainty jewelry-quality Tacs with grippers, helds cap bands securely. Sculptured metal, gold finish, approx. 3/2" wide. Choose RN, LPN, LVN, RN Caduceus or Plain Caduceus. Gift boxed. No. CT-1 (Specify Initials), No. CT-2 (Plain Cad.) or No. CT-3 (RN Cad.) . . . 2.95 pr.

SEL-FIX CAP BAND Black vervet SELFIX CAP BAND Black velvet band material. Self-adhesive, presses on, pulls off; no sewing or pinning. Reusable several times. Each band 20" leng, pre-cut to popular widths: ¼" (12 per plastic box) ½" (8 per box) ½" (6 per box) ½" (6 per box) ½" (8 per box) 4 m (6 per box) 2" (8 per box) 3 or more , .1.50 ea.



	IN MEESES	CUMPANT, BUX	G . AL	rienon	U M 253	r fre tida
ì	OROER NO.	ITEM	COLOR	SIZE	QUANT.	PRICE
Ħ						( and the
ä						
i						
						_
	Use extra sheet for additional items or orders.					
	INITIAL5 as desired: (Good idea for distinctive identification)					
	TO ORDER NAME PINS, fill out all information in box top right, clip out and attach to this coupon.					
	l enclose \$ (Mass. residents add 3% S. T.) Sorry, no COD's or billing terms evailable					

Group Discounts include free Initials and Sack!

6 or more 1.25 ea. 12 or more 1.10 ea. Your initials gold-stamped on holder, add 50¢ per set.



KELLY FORCEPS So handy for every nurse! 5½" stainless steel, fully guaranteed. Ideal for clamping off tubing. Your ewn initials help prevent loss.

No. 25-72 Ferceps . . . 2.75 ea. 6 er more 2.50 ea Yeur Initials engraved, add 50¢ per forceps.



#### Free Initials and Scope Sack with your own Littmann Nursescope!



No. 216 Nursescope.

diaphragm stethoscope . . . a fine precision instrument, with high sensitivity for with high sensitivity for blood pressures, apical pulse rate. Only 2 ozs., fits in pocket, with gray vinyl anti-collapse tubing, non-chilling epoxy diaphragm. 28" overall. Non-rotating angled ear tubes and chest piece beautifully styled in choice of 5 jewel-like colors: Goldtone, Silvertone, Blue, Green, Pink.\*

FREE INITIALS AND SACK! FREE INITIALS AND SACK!
Your initials engraved FREE
on chest piece; lend individual distinction and help prevent loss. Also FREE SCOPE
SACK included, worth \$1, as
described above right, (Free
sacks not personalized; add 50¢ if initials desired.) Ideal for group gifts! Note big savings on quantity orders (left).

13.80 ea. ppd. 12.80 ea. 12 or more,

"IMPORTANT NEW FEATURE: New "Medallion" styling includes tubing in colors to match metal parts. If desired, please add \$1. ea. to all prices above, and add "M" to Order No. (No. 216M) on coupon.

Duty free

SCISSORS Precision-made imported forged steel.
Professional quality. Guaranteed 2 years

31/2" LISTER MINI-SCISSORS liny, handy, slip into uniform pocket or purse Choose jewelers Gold or gleaming Chrome plate finish on coupon BCL No. 3500 Mini-Scissors . 41/2" or 51/2" LISTER SCISSORS

As above, but larger for bigger jobs Chrome tinish only No. 4500 (4½") or No. 5500 (5½") Scissers . . . 2.75

51/2" OPERATING SCISSORS Stainless steel, with sharp/blunt points. Beautifully polished finish. No. 705 OR Scissors . . 2.75 ga.

All scissers above: 1 doz. or more (any style) . . . Your initials engraved, add 50c per scissers

CLAYTON DUAL STETHOSCOPE Light weight imported dual scope; highest sensitivity for pulse rate. Chromed head tubes and chest piece 11/8" bell and 17/8" diaphragm, grey anti-collapse tubing. 4 oz., 29" long. Extra ear plugs and diaphragm included. Iwa initials engraved free. (CD) No. 413 Oual Steth . . . . . . . 17.95 ea Duty free

#### NURSES CHARMS

Finest sculptured Fisher charms,
Sterling or Geld Filled (specify under COLOR on coupon)
For bracelet or pendant chain. Add to your collection! No. 263 Caduceus: No. 164 Cap; No. 68 Grad. Hat; No. 8. Band. Scissors . . 3.49 ea.



Dainty, detailed 14K Gold styles, for on or off duty wear. Shown actual size. Beautifully gift boxed.

Tally girt boxed.

Birthstone Colors (specify on coupon): JAN
Garnet, FEB Amethyst, MAR Aqua, APR Crystal, MAY Emerald, JUNE Alexandrite, JULY
Ruby, AUG Peridot, SEPT Sapphire, OCT
Rose Zircon, NOV Topaz, DEC Blue Zircon.

No. 13/297 Caduceus; No. 13/276 Crass; 5.95 per pair.
No. 1/010 Gen. Cultured Pearl; No. 6/247 Birthstone 5.95 per pair.

PIN GUARD Sculptured caduceus, chained to your professional letters, each with pinback/safety catch. Or replace either with class pin for satety, Gold finish, gift boxed. Choose Ri. LPN or LVN. No. 3420 Pin Guard . . . . 2.95 ea.



ENAMELED PINS Beautifully sculptured status insignia, 2-color keyed, hard-fired enamel on gold plate. Olme-sized, pin-back. Specify RN, LPN, PN, LVN, NA, or RPh. on coupon.

No. 205 Enam. Pin 1.95 ea., 12 or more 1.50 ea.







Handiest for busy nurses. Includes white Deluxe Pocket Saver, with 5½" Lister Scissors (both shown above). Tri-Color ballpoint pen, plus handsome little pen light all silver finished. Change compartment, key chain

No. 291 Pal Kit . . . . . . . 4.95 ea. 3 Initials engraved on shears, add 50¢ per kit.

BZZZ MEMO-TIMER Time het packs, heat lamps, park meters. Remember to check vital signs give medication, etc. Lightweight, campact (1½" dia.), sets to buzz 5 to 60 min. Key zing. Swiss made. No. M-22 Timer . . . . . 4.95 ea. 3 or more 3.95 ea.; 6 or more 3.50 ea



EXAMINING PENLIGHT White barrel with caduceus imprint, aluminum band and clip. 5" long, U.S. made, batteries included (replacement batteries available any store). Your own light, gift boxed. No. 007 Penlight . . . 3.98 ea. Your Initials engraved, add 50e per light.



#### w Kork-Lites Featherweight Style



### All-Weather NURSES' CAPE

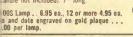
Stay snug in cool weather, dry in the rain. Traditional Navy with Bright Red lining. Finest tailoring of 65% Busron polyester tailoring of 65% busron polyester 35% combed cotton. Zepel treated. 109% Nylon Ouralyn lining. Snap fasteners, arm openings. Matching head scarf, SMALL (up to 34 bust), MEDIUM (35-38.) or LARGE (39-42) specify size on coupon.

No. 638 Kork-Lite Shoe . . . 16.95 pr.

No. 658 Cape . . . . 3 Gold Initials on collar, add 1.00 per cape.

#### HTINGALE LAMP

hentic, unique favor, gift or engraved ! Ceramic off-white candleholder with ne gold leaf trim. Recessed candle andle not included). 7" long.







Endura NURSE'S WATCH Fine Swiss-made waterproof timepiece. Raised easy-to-read white numerals and hands on black dial, luminous markings. Red sweep-second hand. Chrome finish, stainless back. Includes black velvet strap. Gift-boxed, with 1 year guarantee. Very dependable. Includes 3 initials engraved FREE. No. 1093 Nurses Watch . . . . . . . . 19.95 ea.



Fast-Action TOURNIQUET Strong, lightweight 

Nalalie B. Havens SS PEN ld-famous ballpoint, with io-ramous paripoint, with iptured caduceus emblem, Full name E engraved on barrel (include name with coupon), ills avail, everywhere. Lifetime guarantee, 502 Chrome 8.00 ea. No. 6602 12kt, G.F. 11.50 ea.

#### TRI-COLOR BALL PEN

Write in black, red and blue with one ball point pen, the thumb changes point (and color). Steno fine point (excellent rts). Polished chrome finish. A handy accessory for every nurse! 

HORSESHOE KEY RING Clever, unusual design: one knob unscrews for inserting keys. Fine sterling silver throughout, with sterling sculptured caduceus charm. No bead chain to break! No. 96 Key Ring . . . . . . . . 4.95 ea.

#### Pull-Out KEY-KEEPER

#### dates

#### August 10-12, 1973

Moncton Hospital School of Nursing, Moncton, N.B., holding reunion for class of '68. Please contact Ms. Karyn Johnston, 84 Wilson Road, Riverview, New Brunswick.

#### September 3-6, 1973

Workshop on evaluation of student nurse clinical performance, Faculty of Nursing, University of Western Ontario, London. Tuition fee of \$125 includes course fees, accommodation, and meals. The instructor will be Professor Vivian Wood. Registration limited to 30.

#### September 10-11, 1973

American Cancer Society, national conference on cancer nursing, Palmer House, Chicago, Illinois. Sessions open to nurses and nursing students only. No registration fee. For further information, write to: American Cancer Society National Conference on Cancer Nursing, 219 E. 42nd St., New York, N.Y. 10017, U.S.A.

#### September 20-22, 1973

Ontario Occupational Health Nurses' Association, second annual convention, Holiday Inn, London, Ontario. For further information, write to: Ms. P. Read, Head Nurse, Health Service Dept., Victoria Hospital, London, Ontario.

#### September 23-28, 1973

Registered Nurses' Association of Ontario, 17th annual conference on personal growth and group achievement, Delawana Inn, Honey Harbour, Ontario. For further information, write to: Professional Development Department, RNAO, 33 Price Street, Toronto, Ontario M4W 1Z2.

#### October 10-13, 1973

National training conference and 16th annual meeting, Canadian Association for the Mentally Retarded, International Inn, Winnipeg, Manitoba. Conference theme: "Come See - Come Serve." For further information, write to: Alice Moore, Canadian Association

for the Mentally Retarded, Kinsmen NIMR Bldg., York University Campus, 4700 Keele St., Downsview, Ontario.

#### October 12-15, 1973

American School Health Association, 47th annual convention, Sheraton-Chicago Hotel, Chicago, Illinois. For further information and registration forms, write to: American School Health Association, Kent, Ohio 44240.

#### October 17-18, 1973

Sterile Disposable Device Committee of the Health Industries Association, third biennial meeting, Mayflower Hotel, Washington, D.C.

#### October 24-26, 1973

Alberta Hospital Association, annual convention, Jubilee Auditorium, Calgary, Alberta.

#### October 25-26, 1973

Rosehill Institute of Human Relations, third seminar on the application of group psychodynamic theory to management effectiveness, Inn-onthe-Park, Toronto, Ontario, For further information, write to: Conference Director, Dr. Sheldon Heath, Rosehill Institute, 1365 Yonge St., Toronto, Ont. M4T 2P7.

#### October 28-November 4, 1973

International Confederation of Midwives, 16th congress, Washington, D.C. For further information, write to: Pan American Sanitary Bureau, Washington, D.C. 20037, U.S.A.

#### October 31-November 2, 1973

Three-day advanced cardiac care symposium for nurses, The Charter House, Williamsville, N.Y. Sponsored by the School of Nursing, State U. of New York at Buffalo. Fee: \$75.

#### June 16-21, 1974

Canadian Nurses' Association annual meeting and convention, to be held in the Manitoba Centennial Centre Concert Hall, Winnipeg, Manitoba.



#### names

F. Moyra Allen has recently received a senior health scientist award from the government of Canada. Primarily a salary award, it will allow Dr. Allen to develop a research training program in nursing and establish in the McGill School of Nursing a research center for the purpose of "stimulating and conducting research in nursing practice

and health care delivery.

Dr. Allen (B.N., McGill U.; M.A., U. of Chicago; Ph.D., Stanford U., Calif.), a professor in the McGill School of Nursing, Montreal, has been involved in the development of the B.Sc. nursing program and the masters program she now heads. She has written Learning to Nurse: The First Five Years of the Ryerson Program, and is editor of Nursing Papers, published by McGill U. School of Nursing.

Dorothy Cornelius, U.S.A., was elected president of the International Council of Nurses for a four-year term at the ICN congress held in Mexico City in May. She succeeds Margrethe Kruse of Denmark.

Other officers elected are: first vicepresident, Docia Kisseih, Ghana; second vice-president, Margaret Scott-Wright, Great Britain; third vice-president, Verna Huffman Splane, Canada.

Nicole Du Mouchel, Canada, was elected to the 11-member board of directors.



Ms. Cornelius has just completed her term as first vice-president of the ICN. She is currently executive director of the Ohio Nurses' Association, having formerly worked in

areas of administration, teaching, public health, and staff nursing. Active in nursing association work, she has been president of the American Nurses' Association. She has also served as president, a member of the board of directors, and treasurer of the American Journal of Nursing Company.

Ms. Kisseih, chief nursing officer of Ghana's ministry of health, is currently studying at the Boston School of Nursing. Dr. Scott-Wright is professor of nursing studies, University of Edin-

burgh, Edinburgh. Ms. Splane was until recently principal nursing officer, Health and Welfare, Canada.

Ms. Du Mouchel is executive director and secretary registrar, Association of Nurses of the Province of Quebec, Montreal.





Verna Splane

Nicole DuMouchel

Maria Rychtelska of Warsaw, Poland, has been appointed nurse adviser at the headquarters of the International Council of Nurses in Geneva, Switzerland.

Having studied at the Nursing School of the City of Warsaw, and the Teacher's College for Nurses in Warsaw, Ms. Rychtelska took courses in inservice education in hospitals in Roskilde, Denmark, and in teaching medical/surgical nursing at Wayne State University in Detroit, Michigan. Ms. Rychtelska's career has been devoted chiefly to nursing education in recent years as instructor in medical-surgical nursing at the Teachers College for Nurses in Warsaw.

Fluent in Polish and English, Ms. Rychtelska has some knowledge of Russian and Spanish.

Life membership in the New Brunswick Association of Registered Nurses has been conferred on **Sister Florence Darrah** of Saint John and **Grace Stevens** of Fredericton in recognition of outstanding service to the association.

Sister Darrah attended Holy Family Hospital School of Nursing, Prince Albert, Sask.; Saint Francis Xavier University, Antigonish; and Saint Louis University, Missouri. She worked in the dietary department of various Canadian hospitals before returning to Saint John in 1948. A former director of nursing at Saint Joseph's Hospital school of nursing and administrator at

Mater Misericordia Home, she is presently the admitting officer of Rocmaura in Saint John.

Ms. Stevens, a graduate of the Royal Victoria Hospital School of Nursing, Montreal, interrupted her career as industrial nurse for the Fraser Company in Edmundston to serve in the Army Nursing Corps. In 1967, Ms. Stevens joined NBARN staff to help establish a collective bargaining program for nurses. As this program developed, she was employed by the New Brunswick Provincial Collective Bargaining Councils, from which she retired last year.

Ms. Stevens was president of the NBARN for four years, and was instrumental in organizing the Victorian Order of Nurses in Edmundston.



At the spring convocation of the University of Saskatchewan, Helen Roberta Irwin of Indian Head was awarded the Kathleen Ellis prize for the most distinguished graduate in

the school of nursing. This year 84 earned B.S.N. degrees, 15 more than last year.

Sister Catherine Chisholm (R.N., Halifax Infirmary school of nursing; B.N., Dalhousie U.) has been appointed associate director of nursing service at the Halifax Infirmary, where she has been medical-surgical day supervisor.

A member of the Sisters of Charity since shortly after her graduation as a nurse, she has worked in the congregation's three hospitals in Alberta and in their institutions in North Sydney, Nova Scotia.

The Registered Nurses' Association of Ontario has honored Wilma Ballantyne, supervisor of the central supply department, McKellar General Hospital, Thunder Bay, Ontario, by conferring on her the status of Member Emeritus. Ms. Ballantyne, who is a graduate of the McKellar School of Nursing, has been a member of the hospital nursing staff for 40 years.

#### names

Mary Spry (R.N., St. Boniface School of Nursing, St. Boniface, Man.) has been named assistant director of nursing at the Oshawa General Hospital, Oshawa, Ontario. She has worked there in a supervisory and administrative capacity for the 11 years since she and her family returned to Canada from Florida.

Her earlier nursing career brought Ms. Spry from her home base of St. Boniface Hospital to the Oshawa General Hospital, then to the Peterborough Civic Hospital before moving on to The Vancouver General Hospital in Canada's west.

The Mildred I. Walker Bursary Fund was established at The University of Western Ontario Faculty of Nursing by the many students and friends of Ms. Walker. During the 1972-73 academic year awards were given to: Lydia Bahro, Linda E. Demers, and Suzanne M. Robinson.

An honorary degree of Doctor of Letters was conferred on Sister Catherine Gerard Herlihy at Saint Mary's University spring convocation. She was administrator of the Halifax Infirmary and founder of the Infirmary's school of nursing assistants.

In 1965, Pope Paul VI bestowed on Sister Catherine the Holy Cross Pro Ecclesia Pontiface, one of the highest honors of the church. In 1967, she received Canada's Centennial Medal for service to the people of Nova Scotia.

Sister Catherine was, at one time, president of the Registered Nurses' Association of Nova Scotia. She is now retired at Mount Saint Vincent, Wellesly Hills, Mass.

E.A. Electa MacLennan was presented with a life membership in the Atlantic Region, Canadian Association of University Schools of Nursing (CAUSN) in April 1973. The award, presented in absentia at the annual meeting of the Atlantic Region CAUSN, was for "her contribution to nursing education in the Atlantic region and the formation of the organization."

At the same meeting, Dr. Helen Naum was presented (in absentia) with an honorary membership for her contribution to university schools in the

Atlantic region.

Nicole David of the nursing faculty of Laval University is the first nurse to be

appointed to the council of social affairs for the province of Quebec. The 15 members on this council are appointed for four years and represent health and social services, family-centered associations, various socio-economic groups, labor unions, and universities.

Ms. David (R.N., Hôpital Maisonneuve School of Nursing, Montreal; B.Sc.N., U. of Montreal; M.N. (child care), Pittsburgh U.) was formerly night supervisor of the intensive care unit, Hôpital Maisonneuve, and has been a clinical instructor in pediatrics and cardiology.

Dorothy Wylie is now assistant executive director, patient care, at Sunnybrook Hospital, Toronto, where she has been director of nursing since 1971

Her studies (Reg.N., St. Michael's Hospital School of Nursing, Toronto; P.H.N., U. of Toronto; B.Sc.N., New York University; M.A., nursing, Teachers College, Columbia Universi-

ty, New York City) have interlaced a nursing career that has included several years at New York Hospital, Cornell Medical Center, New York, and two years as assistant director of clinical nursing at Scarborough Centenary Hospital, West Hill, Ontario.

Ms. Wylie is currently president of the Freeway chapter of the Registered Nurses' Association of Ontario.

Dorothy Wyatt (B.A., B.Ed., B.N.) has been for three years on the city council of St. John's, Newfoundland.

While her husband studied medicine, she worked as director of nursing for the Red Cross in Halifax. Now she is Don's (family practice) office nurse, looks after their two children, and finds time to hold political meetings twice monthly, have a weekly five-minute radio show, and for a year to write a twice-weekly column for St. John's Daily News. A social issue she sees as pressing is the need for public housing for the poor.



**Next Month** 

#### The Canadian Nurse

- ICN Congress Report
- Helping the Handicapped to Communicate
- Problem-Oriented Charting

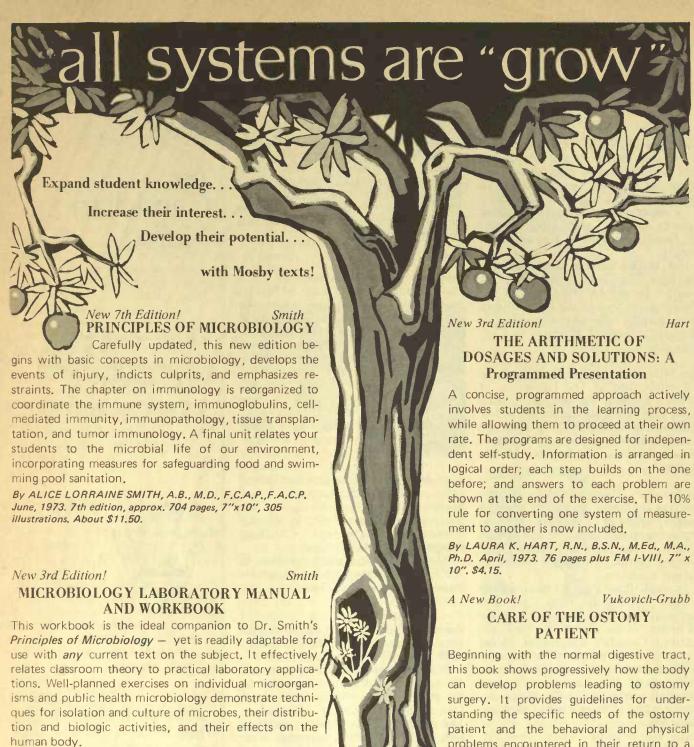


#### Photo credits for **July 1973**

Health Sciences Centre (Winnipeg General Hospital division), front cover and p. 31

The Owen Sound Sun-Times, Owen Sound, Ont., p. 11

Ron Vickers Ltd., Toronto, Ont., p. 8



problems encountered in their return to a productive life.

By VIRGINIA VUKOVICH, R.N., E.T.; and REBA D. GRUBB, Medical Writer; foreword by DONALD G. SHROPSHIRE; illustrations by TRAVIS L. MAYHALL. September, 1973. Approx. 136 pages, 6" x 9", 23 illustrations. About \$5.00.

## TIMES MIRROR

BY ALICE LORRAINE SMITH, A.B., M.D., F.C.A.P., F.A.C.P.

June, 1973. 3rd edition, approx. 192 pages, 7%" x 10%",

35 illustrations. About \$5.50.

INSTRUCTOR'S NOTE: To receive a complimentary copy for firsthand evaluation, write to the Textbook Department mentioning your position, course, and enrollment.

THE C. V. MOSBY COMPANY, LTD. • 86 NORTHLINE ROAD, TORONTO, ONTARIO M4B 3E5 18 THE CANADIAN NURSE **JULY 1973** 

# Nurses, smoking, and schoolchildren

The authors present some suggestions to help reduce the number of smokers and of cigarettes smoked in Canada.

F.R. Wake, Ph.D., Eleanor Thomas, B.A. (Hons.), and Jane Bergin, M.A.

A brief look at the history of tobacco smoking may remind us of the incongruities in smoking behavior that puzzle us today. One of the famous early smokers, Sir Walter Raleigh, demonstrated how unpleasant the first few experiences can be—a fact bolstered by countless young men over the years as they experimented behind the barn. King James the First found the act of smoking so intolerable that he legislated against it (with a lack of success that seemingly still deters the federal government from taking similar brutal action).

In spite of these hindrances, smoking of various kinds continued and grew slowly in popularity until World War I. Then, for reasons of convenience and, some say, safety, the cigarette suddenly became the soldier's friend and the habit was well launched for males.

At that time, strong efforts were made to stop the young from adopting the habit. The terrible effects of smoking — stunted growth, social ostracism, and all the other unverifiable happenings — were detailed for all to know. Perhaps because the prognostications seemed so improbable to the young, they didn't "buy" and, in growing numbers, turned to the weed. (It is ironic that in principle the tobacco antagonists were so right in their fears; yet, lacking adequate confirmation, their propaganda seemingly worked against them.)

By World War II, the cigarette was truly the soldier's friend. However, IULY 1973

many soldiers in this war were female, so it was natural and inevitable that there should be a rise in the number of women who smoked. Post-World War II saw steady increases in the numbers of persons smoking, the numbers of cigarettes smoked, and also the beginning of determined research to explore the strongly suspected deleterious physical effects of using tobacco.

In 1964, the U.S. Surgeon-General's Report made plain the dangers of cigarette smoking. The response was immediate: led by the medical profession, large numbers of smokers gave up the habit. People were behaving rationally, as they should, and smoking was expected to be reduced markedly in a short time.

#### Old myths die hard

But people are people and often do not behave rationally. Old habits die hard and so do old myths of "sophistication," "masculinity," "social ease," "relaxation," and "it won't happen to me." Many workers in the field became discouraged: it simply didn't make sense that people not only would continue to smoke, but also that others

The authors are associated with the Department of Psychology, St. Patrick's Campus, Carleton University, Ottawa. The research was supported by Health and Welfare Canada, as part of a larger research project, Project No. 318-4-3, Grant No. 2042-01.

would deliberately begin to smoke in the face of the obvious danger.

Research proliferated to provide data for ever-increasing propaganda against the cigarette. Pressure from government exacted concessions from the tobacco industry. Therapeutic clinics sprang up to help those who could not help themselves. In spite of all these efforts, the antismoking gains have not been spectacular. In fact, the research detailing the increasing rate of smoking in young females, the greater difficulty females have in ceasing to smoke, and the yearly increase in per capita consumption are viewed by many as failures.

And so the gloom remains. Many suspect the menace cannot be beaten, and statistics from the tobacco industry suggest that the industrialists are winning.

But they are not. What really has happened is that health authorities erred in believing that a form of social behavior of over 40 years standing could be reversed simply by showing it was dangerous. Educators underestimated the forward momentum of the smoking movement and did not realize it would be necessary to halt the habit before reversing the trend.

But halt the increase in cigarette smokers we have for all except the 15- to 19-year-old age group of females. Furthermore, if the numbers of smokers of all types of tobacco had increased between 1965-70 at the rate anticipated in 1965, there would

THE CANADIAN NURSE 19

have been nearly 400,000 more than there are (both sexes, ages 15 years and over).

And, if Canadians follow their common pattern of adopting behaviors from the United States after a one- or two-year delay, it can be anticipated that the Canadian per capita consumption, like that of the U.S., will level, rather than increase, as has been the case in the past.

The per capita consumption of cigarettes, so worrisome to readers of newspaper articles, is a strange statistic indeed. It may, in fact, be subject to strange manipulations and, in any event, is only part of the story of cigarette smoking. So the unemotional look at the smoking scene tells us we are winning — not winning "as big" as we should like, but winning nevertheless.

#### Program in schools

This leads to the first point to be considered in an antismoking program in schools. Many students do not know the facts about cigarette smoking and, for that matter, neither do the teachers.

A year ago, while pursuing a research problem with an honors student, we held a discussion with a seventh-grade class. The point was made that more persons do not smoke than smoke. The teacher not only contradicted the statement, but said more grade seven children smoke than do not smoke. She was wrong. Data for this age group in Canada vary, with an approximate range of 9 percent to 25 percent who smoke. Combine this teacher's belief with the following research findings, and the problem of persuading school children not to smoke begins to grow.

"Many grade seven students live with the false belief that a larger number of their own age smoke than is actually the case. Similarly, they overestimate the incidence of adult smoking. A higher proportion of student smokers than nonsmokers overestimat-

ed the incidence of adult smoking."1

In addition, other data from the same research show that students who smoke heavily believe it will be more difficult to stop smoking than do light smokers. The students also lacked knowledge of the effect of smoking on various illnesses. (Some of the findings here were ludicrous; for example, only 45 percent of the sample answered correctly that smoking did not cause polio.)

This information may give the public health nurse an idea of where to start with children. She could begin her efforts by stressing facts to dispel the defeatist atmosphere that overhangs the smoking scene, to place smoking in the proper perspective with regard to health, to repudiate the atmosphere of status connected with smoking, and to minimize to the smoker the supposed difficulties in quitting when one is young.

The methods used to introduce such facts to students have been detailed in a section written for the publication Readings in Public Education, presently in press and to be distributed by the International Union Against Cancer.<sup>2</sup> There is no need to cover the same ground here. However, the public health nurse must face a real problem in assessing what method to recommend for the particular teacher in the particular class in the particular school. The ancient and tightly clutched educational belief that good materials are good anywhere and anytime probably has led to a considerable economic drain in money, time, and effort for little return — except in massive boredom.

Of course, if the public health nurse studies the teachers and students she wishes to teach, it follows that she must assess herself to maximize her strengths and minimize the horrors of her weaknesses. For example, people who know me are aware that I use a blackboard rarely; when I do, I use it with the lack

of skill associated with the truly naive. So, when I am on tap, it is best to have prepared drawings if illustrations are needed.

#### Review of literature

There has been a belief for a number of years that a smoker's personality exists — a set of predispositions that led the smoker to the cigarette in a nearly straight line. Until lately, the search has been unrewarding and smokers began to join the ranks of alcoholics, homosexuals, "cruel" boys, and others in being described as differing from the normal only in the use of alcohol, sex, and violence.

Recently, however, Thomas 3 examined the literature, noting the following findings by several researchers: Smith reported that extraversion and antisocial tendencies are associated with cigarette smoking, but that more data are needed to confirm tentative findings that link smoking and external orientations, impulsiveness, orality, and poor mental health. Veldman and Brown<sup>5</sup> related smoking to low self-esteem and negative attitudes to work, reality, and parents, but with positive attitudes to peers. Other evidence has been adduced by Jacobs and Spilken, <sup>6</sup> Berger, <sup>7</sup> Salber and Rochman,8 Stewart and Livson,9 and Clausen. 10

However, Thomas continues, most of these reports involved college age or adult subjects as the smokers, and thus are concerned more with *continuation* of smoking patterns than with *initiation* of the habit. (The United States Public Health Service reports that most people who smoke began to do so before 18 years of age. 11)

These data are of real interest, but tell little of the relationships between personality and early experimentation with cigarettes — an area of concern to nurses working to prevent smoking. Perhaps the most pertinent study was carried out by Smith on high school and

junior high school students. His research found smokers to be less agreeable, possessing less strength of character, less self-reliance and social maturity; however, smokers rated higher in extraversion.

Thomas concluded the review of research by stating: "Studies on personality and smoking have generally been cross-sectional in design, comparing smoking subjects with nonsmoking subjects on various characteristics. Most studies have concerned subjects of college age or older, many of whom are continuing rather than beginning to smoke. A few studies have been reported on younger people, but none on students below the grade eight level in school, and none of these studies separated experimenters from regular long-term users of cigarettes with a longitudinal design. The few available longitudinal analyses have related presmoking personality with adult smoking habits. The initiation of smoking by young people and its relation to psychological factors have not been directly studied ..."12

#### Research findings

Thomas, a member of the St. Patrick's College Smoking Research Team, undertook to examine data collected earlier on approximately 2,500 Eastern Canadian urban students "... to investigate relationships between personality factors and grade seven smoking behavior, and between personality and the initiation of smoking by former nonsmokers ..."<sup>13</sup>

Students completed specially constructed questionnaires on smoking behavior and selected scales of the 1953 Revision of the California Test of Personality, Intermediate Form AA (Thorpe, Clarke and Tiegs). 14

The principal findings are of interest, if not spectacular:

 More nonsmokers than smokers scored high in sense of personal free-IULY 1973 dom in all sex and age groups.

- More nonsmokers than smokers scored high in feeling of belonging and freedom from withdrawing tendencies. This was especially so of young females.
- Social skills scoring bore no relationship to smoking.
- Nonsmokers showed dramatically better adjustment on the family relations scale.
- Older male nonsmokers scored higher than did smokers on the community relations scale.
- More students who had "never smoked" than "ever smoked" scored high in personal, social, and total adjustment, with the greatest differences for the younger female subgroup.

As far as personality and starting to smoke are concerned:

- Starting to smoke was not related to self-reliance, feeling of belonging or freedom from withdrawing tendencies, social skills, school relations, or community relations.
- Nonstarters scored higher than starters in sense of personal freedom and in family relations.
- At this grade level, the dynamics of experimenting and starting to smoke differ from those of continuing to smoke, especially so for young female students.

#### **Putting findings to use**

How can these findings be put to use in a school? One way would be to devise separate programs for those who have started to smoke and those who have not. This has the advantage of concentrating on prevention in one group and conversion in another.

More specifically, the factors strongly associated with nonsmokers on a continuing basis are: feelings of belonging; freedom from withdrawal; good school relationships, mainly in young females; and better community relationships.

The following hold for both continuing and taking up smoking: nonsmokers had a greater sense of personal freedom, and stronger family relationships.

Interestingly, no significant positive traits appear for smokers over non-smokers on either a continuing or on a taking up basis.

So, school children could be separated into smoking and nonsmoking groups. The smokers could be advised of the relationship of smoking to lack of personal freedom and of strong family relationships. Nonsmokers could be told of the association of nonsmoking with closeness to others and the real world, good relationships in school and community and with family, plus a sense of personal freedom.

There are, of course, some obvious problems. School-age smokers might not want to identify themselves. Also, classroom schedules might not be amenable to the needed manipulations. And exposing a group of smokers to obvious strong propaganda might have social side effects. Finally, it might be difficult to concoct stories to avoid the implication of a causal effect between smoking and "personal-social" characteristics, exemplified by the statement "smoking causes. . " which has run its course in the misuse of data on smoking behavior and school grades.

Perhaps more important, school children would again be faced with propaganda stemming from the harm done by cigarettes and smoking. Not only might the repetition turn them off, but the reminder of the danger could lead some males to experiment. What might be done is to start from the other end and talk to all students about the development of personal freedom and how such achievement permits him or her to have a say in what happens in life, to choose friends, and even to choose not to smoke, no matter the behavior of friends or adults.

Attention could be given to the need for balance between being comfortable with people and comfortable alone,

THE CANADIAN NURSE 21

noting that those who are not comfortable in either situation sometimes turn to dangerous supports, such as cigarettes. The health educator could stress the importance of good family, school, and community relationships, with examples of how using such benefits can result in less friction, less unhappiness, and no need to smoke cigarettes. In some respects, this approach is similar to the American Cancer Society's "education for health" program.

An even more ambitious project has been suggested for a Toronto high school. A group of health-oriented students has proposed that education about cancer be integrated with the curriculum. For example, research might be taught as part of biology, understanding of statistics as part of math, with cancer as the illustrative material. (Smoking, of course, would provide excellent material.)

In this fashion, not only would activity and data appear naturally and appropriately, but reinforcement — the factor so important in learning — would also be achieved painlessly in many and varying contexts. Although it may be difficult for students to alter a curriculum, it would not be amiss for public health nurses to take the lead in suggesting, organizing, and building such programs. In fact, many teachers may welcome "real life" illustrative material.

If the public health nurse has an opportunity to meet with members of the local home and school association, the same approach can have value. Parents may be able to ignore the negative and move toward warmer parent-child relationships.

The foregoing suggestions are aimed at reducing the number of smokers and of cigarettes smoked in Canada. However, they also can be used to combat alcohol, drugs, and so on. Carried out by exemplary adults, in a low-key atmosphere, they may be helpful in winning those games that society has no choice but to win — and soon.

There is no question but that the

momentum is turning in the direction of nonsmoking. The main factor yet to be determined is "What shall be the price of victory? How many sufferers before the war is won?" I submit that wars (and we are at war with cigarette smoking) are won by confident people, tirelessly applying themselves to the task in little and in big ways.

If we accept the progress already achieved, work to encourage all those who have labored earnestly, and refuse to follow the lead of the pessimists, the ill health due to smoking will diminish and, eventually, disappear. There is "no room at the inn" for pessimism.

#### References

- 1. Wake, F.R. et al. The smoking behaviour of grade seven children in an eastern Canadian city. 1972 (In press)
- 2. International Union Against Cancer. *Readings in public education*, edited by A.G. Maclaine. Geneva, Switzerland, 1973. (In press)
- 3. Thomas, Eleanor M. Personality fuctors related to smoking and to taking up smoking by public school students. Ottawa, Department of Psychology, Carleton University, Aug. 1972. (Research Project)
- 4. Smith, G.M. Personality and smoking: a review of the empirical literature. *In* Learning mechanisms in smoking, edited by William A. Hunt. Chicago, Aldine, 1970. p.42-61.
- Veldman, D.J. and Brown, O.H. Personality and performance characteristics associated with cigarette smoking among college freshmen. J. Consult. Clin. Psychol. 33:109-19, Feb. 1969.
- Jacobs, M.A. and Spilken, A.Z. Personality patterns associated with heavy smoking in male college students. J. Consult. Clin. Psychol. 37:428-32, Dec. 1971.
- 7. Berger, E.M. MMPI item differences between smoker and non-smoker college freshman males. *J. Consult. Clin. Psychol.* 36:446, June 1971.
- Salber, E.J. and Rochman, J.E. Personality differences between smokers and non-smokers. Arch. Environ.

- Health 8:459-65, 1964.
- Stewart, L. and Livson, N. Smoking and rebelliousness: a longitudinal study from childhood to maturity. J. Consult. Clin. Psychol. 30:225-9, June 1966.
- 10. Clausen, J.A. Adolescent antecedents of cigarette smoking: data from the Oakland growth study. *Soc. Sci. Med.* 1:357-82, 1968.
- 11. U.S. Dept. of Health, Education and Welfare. Public Health Service. Smoking and health. Report of the Advisory Committee to the Surgeon General of the Public Health Service. Washington, U.S. Govt. Print. Off., 1964 (Its Publ. No. 1103)
- 12. Thomas, op. cit.
- 13. Ibid.
- 14. Thorpe, Louis P. California test of personality. 1953 revision. California Test Bureau, Monterey, 1953.

### First aid for drivers

"It is a function of the medical [and nursing] profession to promote and inspire the teaching of first aid."

Hanns Pacy, MB, BS, MD, FRACGP

t is a sad fact that victims of accidents continue to die on our roads because people do not know what to do when confronted with traffic injuries. The best hospital is of no use if the patient is already dead or beyond help. This, in Australia, is highlighted by the fact that most road deaths occur on highways (two thirds in New South Wales) and often far from the nearest properly staffed and equipped hospital. Under these conditions the lives of victims can depend on the right measures taken by a passerby, because he has a most important weapon in his hand — time.

#### Fix the time

A glance at the clock is the first thing anyone arriving at an accident

From the Coweamhah Clinic and Myall Valley Institute for Regional Research, Tea Gardens, New South Wales, Australia, Reprint requests to Houghstreet, Tea Gardens, New South Wales 2324, Australia.

should do. In the excitement, time slips away quickly and it is very difficult later to pinpoint the time of the accident. Witnesses vary greatly in their recollection. Yet for the later-arriving skilled rescuers, it is vital to know how long ago injured persons have stopped breathing or moving. This information affects the value of artificial respiration and other measures that may have to be given priority at the expense of other injured victims.

Proper parking

An accident scene can be protected from run up accidents by the way the next arriving ears are parked (Fig. 1). Slow down gently and bring your car to a stop at a sufficient distance from the accident so that ambulances and doctors' cars can be driven right up to the casualties. Park far enough from

Reprinted with permission from the *Journal of the American Medical Association* 223:10:1151-3, and with the permission of the author, Dr. Hanns Pacy.

the edge of the road to cover the scene and, at night, illuminate it with your headlights. Leave your battery switched on and let your left signal produce an intermittent blinking signal. The driver behind you must park about one foot further toward the edge of the road, so as not to obscure your blinking signal and he also must switch on the same blinking signal. In this way the accident scene is already largely protected by the time the next cars have stopped and time is gained for urgent lifesaving measures.

#### Assessment

It is necessary for the efficient utilization of skilled rescue to get an accurate, concise, and complete message in a minimum of time. Where persons are injured; nobody should be expected to rely on memory. Every car, by law, should be equipped with emergency message forms in triplicate, so the assisting driver can immediately know what to look for (Fig. 2). One person takes the original message to the nearest

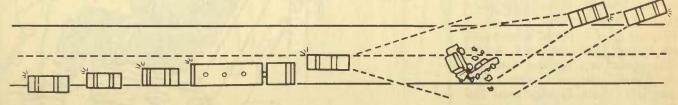


Fig 1.-Staggered parking (From Pacy<sup>1</sup>). Cars parked facing traffic must shine their headlights on crash, but only if this is possible without blinding oncoming traffic.

#### URGENT ACCIDENT REPORT! Accident at about \_\_\_\_\_ o'clock Time of message\_\_\_\_ Exact location of accident \_\_\_\_\_ HOW MANY Unconscious \_\_\_\_\_ Breathing \_\_\_\_\_ Not breathing \_\_\_\_\_ Receiving mouth-to-mouth resuscitation Look serious — Lightly injured \_\_\_ NEEDED (Encircle) Ambulance, Doctor, Police, Tow Truck, Rescue Van (Trapped) Fire Department

telephone, one copy is held by a person who stops all oncoming cars, asking whether a two-way radio, a doctor, a nurse, or a trained first aider is in the car, and the last copy is held at the scene of the accident and sent to the hospital with the ambulance. The importance of such a standardized primary message just cannot be overstated.

Remove danger

Do not touch a car onto which high tension power lines have fallen unless you are sure the power has been switched off or someone, who knows exactly how to do this, has removed them.

If the engine of a crashed car is still running, switch it off.

Someone must make sure that nobody smokes at the scene of the accident.

Flagmen must be posted at least 500 yards up and down the road, clearly visible in the dark (yellow raincoats, white shirts, newspaper tucked into collar, etc). These flagmen must not obscure the lights of any parked cars, should make use of any available flares

and warning triangles, and make sure they are not mistaken for hitchhikers.

#### Remove from danger

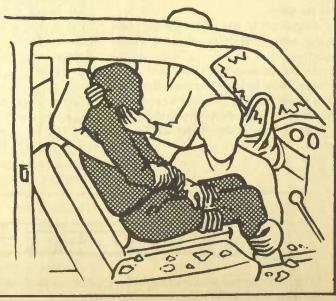
The removal of the injured from vehicles is best left to skilled rescuers. Often the car is the only available shelter anyway. However in certain circumstances (leaking gasoline tank and

Fig 2.—Every car should carry these message forms.

smell of smoldering cigarette butts or dangerous position of crashed car) they just have to be removed. There are a number of good methods for doing this. However, before removing a person from a car, make sure that his airway is clear. To be sure that it is, the head of an unconscious sitting victim. who is slumped forward, must be held up with the chin supported forward because the kinking of the paralyzed larynx may cause suffocation. After this, the seat must be slipped into its most backward position if possible. Figure 3 shows how three helpers can remove such a victim.

If only one person is available, the head can be supported by a collar fashioned from sheets of newspaper, folded about five inches wide and wrapped into a triangular bandage or similar cloth. Rautek's grip can then be used to lift the weight of the victim with the victim's forearm, held from behind, with the rescuer's forearms on both sides of the chest (Fig. 4). The rescuer transfers the weight of the victim from the seat onto his thighs, which become a slide, as the rescuer changes to a kneeling position and lets the victim

Fig 3.—One rescuer takes up weight of head, securing the airway and making sure its position in relation to body does not change, the second applies Rautek's Grip, and third lifts legs out of car.



gently slip onto a blanket on the ground.

When a person has to be dragged out of danger just a few yards, Rautek's carry can be used with the victim's clothing as a handle, but it is essential that the man in front supports the head securely and makes sure that the position of the head in relation to the body does not change (Fig. 5).

#### Save life (breathing, bleeding)

Make sure all unconscious persons are on their sides and cannot inhale blood, vomit, and other material. Having rolled the victim on his side by taking his arm and the trousers at the hip, remove dentures and other obstructing material from his mouth and wipe it out with a handkerchief or the like. When entering the victim's mouth with the finger, use a clothespin or strong wooden spatula to prevent the possibility of being bitten. Figures 6 and 7 show two classic positions of victims on their sides and whichever you choose (this depends on what other injuries the person has), make sure that the victim's head is sufficiently cushioned to prevent a kink in the neck.

Mouth-to-mouth resuscitation must be given as soon as a person stops breathing and must be maintained until skilled rescuers arrive. If, however, it is certain that a person has not been breathing for 15 minutes or more, the value of this procedure must be weighed against the demands of other casualties.

The value of cardiac massage in victims of serious traffic injury is questionable unless simultaneous intravenous infusions are available. In victims without apparently serious chest injuries it can be tried.

If the source of bleeding is not obvious, cut away clothing if necessary to locate the bleeding point. Most bleeding can be stopped by a pad pressed onto the bleeding point. Such a pad (clean handkerchief, sterile dressing, and other clean material) can be held in position by a triangular bandage or similar cloth. A limb that is bleeding should be elevated. If this is not possible and bleeding continues, tie a flat object (flat stone or block of wood) over the tied-on pad with a second triangular bandage. This almost always does the trick.

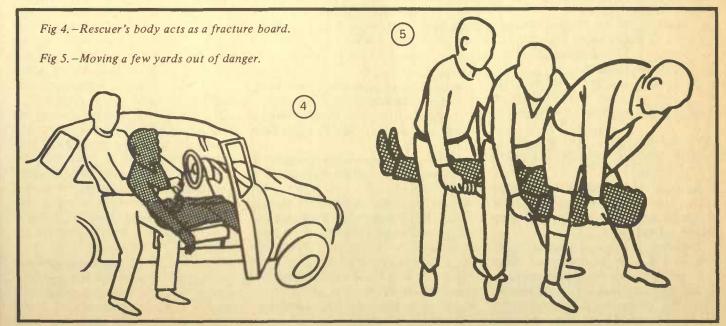
Having done all this, you can now not only be but also appear to be a good samaritan. Reassure the injured and relatives. Ask conscious victims to adopt a position of least pain and improvise cushions and supports. Do not cover up wounds. Leave this to the now imminent arrival of skilled medical teams who will want to see all injuries before they use the infinite variety of technical aids now available to a modern ambulance service.

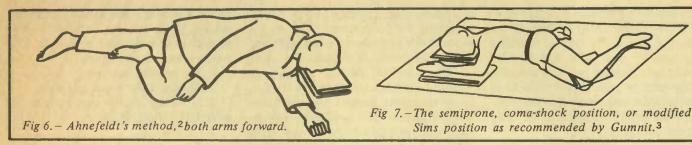
Every car should carry:

- 1. Standardized Message forms.
- 2. A strong tongue depressor or all wooden clothespins.
  - 3. Newspaper.
- 4. Four triangular bandages with safety pins.
- 5. Large sterilized combined dressings and sticky tape.
  - 6. A strong pair of notched scissors.
  - 7. Mouth-to-airway rescue tube.
  - 8. Flashlight.
- 9. A small block of wood (about 1 inch high and 2 inches square) with rounded corners.

#### Comment

As a result of my experience in going to the aid of road casualties with a rescue team on Australia's National Route No. 1 for 17 years, 50 miles (80 km) from the nearest hospital that was staffed and equipped to receive casualties, the above recommendations of course have not been fabricated out of thin air. They are entirely based on personal observation of motorist behaviour at the scene of accidents often long before the arrival of ambulances.





The commonest mistakes made are:

- 1. Placing unconscious persons supine so that inhalation of blood and vomit can kill the victim within minutes. The frequency of this error alone justifies the introduction of first aid measures into any driver-training schedule.
- 2. Haphazard parking makes it impossible to get specially equipped vehicles close to the injured.
- 3. Traffic guards are posted too close to the scene and are poorly visible.
- 4. Casualties suffer further injury by being needlessly dragged out of cars.
- 5. Even slightly injured persons are left lying in the middle of the roadway.
- 6. Finding out at what time the accident took place can be an impossible problem.
- 7. No one bothers to support the heads of unconscious persons, trapped in cars, whose airways are paralyzed and obstructed due to their slumped-over position.
- 8. Panic-stricken, exaggerated, incomplete messages waste time and lead to the unnecessary dispatch of skilled staff to remote accidents.
- 9. There is a general reluctance to do mouth-to-mouth resuscitation as long as "ambulance and doctors are on their way."
- 10. The one thing everyone unfortunately seems to remember is to apply a tourniquet.

I would be surprised if this state of affairs was limited to Australia or the 495 missions carried out by my team between 1964 and 1970.

Naturally, when instructing lay persons one has to be dogmatic. Many will quibble with the "15-minute-nobreathing" rule and not doing mouth-to-mouth resuscitation. Imperceptible respiration (to the lay observer) may

have gone on. Academically, four minutes without breathing will render an injured person nonresuscitable. Cardiac massage in cases of multiple injuries and chest injury is another bone of contention. There are other methods of carrying victims apart from those described. But at least what I have reported is practical experience and tried-out procedure and has been developed in consultation with a senior police driving instructor who has instructed and examined drivers along these lines for some time.

Instruction designed for all drivers cannot be by necessity as comprehensive as a full basic first aid course.

It is a function of the medical profession to promote and inspire the teaching of first aid.

This paper describes what a driver might be taught. A medical practitioner confronted with a traffic accident will, of course, use a quite different and much more sophisticated approach, such as I have detailed in my glove-compartment manual.<sup>4</sup>

#### References

- 1. Pacy H. First aid for motorists. *Med. J. Aust.* 2:280, 1970.
- Ahnefeldt, F.W. et al. First aid in critical emergencies. Ciba Found. Symp. 16:5, 1968.
- 3. Gumnit, R.J. The medical management of closed head injuries. *Geriatrics* 22: 112, 1967.
- 4. Pacy, H. Road Accidents Medical Aid. Edinburgh, E & S Livingstone Ltd.; Baltimore, Williams & Wilkins Co., 1971.

Figures 3, 4 and 6 are reproduced with permission from: Pacy, H. (1972). *Road Accidents* — *Medical Aid*. Edinburgh: Churchill Livingstone.

## Crisis intervention after the birth of a defective child

Sensitive intervention by staff helped the author and her husband cope when their first child was born defective.

#### Barbara Stanko

While a student, I was assigned the care of a woman who had just given birth to her first child. It was particularly sad because she and her husband had wanted a child for several years, and their baby was an acephalus. I was, unable to convey to this patient how badly I felt for her. When she made a few attempts to discuss her child with me, I changed the subject quickly. I had never been more ill-at-ease with a patient, nor felt more helpless. Because I could not find any answers to her "whys," I tended to spend more time at the nursing station than in her room.

Somewhat ironically, our first child was born with a severe encephalocele. But I was not left alone. Because of sensitive intervention by the postpartum ward staff, my husband and I were better able to cope with the birth and ultimate death of our son.

The birth of our baby was perhaps the greatest crisis in our married life, and my husband and I learned a great deal through our suffering. Because of our experience, I feel I have become better able to help other parents who have a defective child. And perhaps I can help you understand some of the principles of crisis intervention following the birth of such a child.

#### **Empathy important**

The nurses who helped my husband and me most were sensitive to our needs, used common sense, and, most important of all, truly cared about us. Not all nurses were able to convey their empathy verbally. One nurse brought me a bun from the cafeteria because I had said I liked them. When handing it to me she said, "I don't know what to say, but I wanted to show you that I feel so badly for you and would like to do everything possible to make your stay in hospital happier." It was not important that she could not express her feelings — after all, what was there to say? The important thing was that she was another human who knew what I was feeling.

Empathy must be genuine, however. It must have its roots in the heart, not the brain. I could easily distinguish the nurses who really cared from those whose objective it was "to encourage the patient to verbalize her emotions" merely because their course in nursing care planning had emphasized that approach to crisis. Not everyone is able to empathize with the parents of a defective child. If you cannot, do not pretend.

#### Reactions

In the beginning, I said many things I did not mean. I continually asked the nurses if my baby had died — I suppose because, if he were dead, I would not have to cope with his dying (the doctors had assured us that he could not live long). It was important to me

that my tears, my anger, and my questions were accepted without censure.

It is essential to recognize that, immediately following the birth of a defective child, the parents are very concerned with their own reactions to the birth. They do not think of the child as an individual until they are able to cope with their reactions, especially if they have not seen the child. A perceptive nurse waits for and recognizes cues that indicate the parents have overcome the initial shock and are ready to accept the child as more than an "it." For 24 hours following the birth of our baby, I thought of nothing else but the experience.

On the second day, when I asked an instructor about her student nurses, she pointed out to me that I was showing an interest in something else for the first time since the birth of our baby. She asked me if I knew what had happened in the world during the last 24 hours. Then she told me an amusing story about her children.

When she left, I realized with a shock that I did not know anything that had happened in the last day. I had not cared about how I looked or about what was happening elsewhere.

I made an appointment with the hairdresser, caught up on the news, and began to think about the future.

#### Child is a person

When a parent demonstrates that he/she is beginning to think about the child as a person, remember to treat

The author is an instructor at the Misericordia School of Nursing in Winnipeg.

**IULY 1973** 

the parent as a parent.

My husband and I were discouraged by everyone from seeing our child. More than once, the nurses asked, "You won't go to see the baby, will you?" Whenever they discussed the baby, they described the defect. Because the doctors, interns, and nurses all had different ways of describing the defect, my husband and I became confused and thought our child was grotesque. I wanted to ask "What color is his hair?" "How big is he?" — questions that a mother asks. But everyone talked about how large his head was, and so I did not ask.

I suggest that, if it has been decided that the parents should not see their child, only one person, preferably the physician, describe the defect or prognosis to them immediately following the birth of the baby. The postpartum staff and other attending physicians should be told exactly what has already been said to the parents and they should be cautioned to answer only the parents' questions without adding to the original description. I strongly advise that the nurses who care for the mother see her baby if at all possible. Then, they will be able to tell the mother about the child himself — not just his defect.

Because of the variety of descriptions we received about our baby, I believed him to be horribly deformed. We were aware that he would probably live longer than we had originally thought. This meant we would leave him in hospital. I became afraid that no one could love him because of his defect, and depressed by the idea of leaving him with people who would think he was ugly.

The head nurse visited me one day, noticed I was unhappy, and sat down to talk to me. I knew she was busy, yet cared enough to take time to sit with me. I told her what was bothering me. She said, "You're a nurse. Have you never loved a patient who was physically ugly, but whom you thought was beautiful?" Of course, like all nurses, I have many memories of patients with physical or mental defects who were dear to me. Her visit was reassuring.

My husband and I became extremely anxious to see our child, but each of us convinced the other not to go against the doctor's wishes.

One night, I dreamed that I was eight months pregnant and the child had died. The physician removed the baby in his office, and I left the office to attend a class reunion. In my dream I pestered everyone at the reunion by repeating, "I really have been pregnant, you know." When I awoke, I realized that I felt as if I had never given birth. I had waited nine months for nothing.

I decided to see my baby.

The nurses obtained permission from the obstetrician for me to visit the baby on the pediatric floor. The nurse who had cared for me during my hospital stay accompanied me. I was nervous and frightened. She squeezed my hand and said, "I think I know what you are feeling. I am a mother too." It was the first time someone had acknowledged verbally that I was a mother.

#### Introduction to son

The nurse on the pediatric floor was expecting us and led us into the baby's room. She held my hand and introduced me to my son. She did not really have to — he looked just like his father.

I wondered why no one had thought to tell us that. He had so much hair and it was so fair. And he was big! Why hadn't they told us? I was aware of the encephalocele, but only because it was part of him. I felt the pride of giving birth and joy in knowing that others could love him. I asked the nurse to call him by his name - I wanted him to be an individual, not "Boy Stanko." I wanted to touch him, but the nurse stood in my way. (Was it so terrible to want to touch my own child?) She took me to the door and said simply, "We will love him." I could have hugged her!

When I returned to the ward, I was jubilant. I refused the sedation ordered by the obstetrician and tried to make him understand how much better I felt. He was perplexed.

My husband saw the baby the next day and his reaction was like mine.

Because the visit to our baby contributed so much to our ability to cope with this experience, I believe all parents should see their defective child. I am fully aware that obstetricians do not always agree. For this reason, it is the nurse's responsibility to recognize cues indicating that the parents wish to

see their child, and report to the obstetrician.

On the day I was to leave the hospital, a friend of mine, a nursing instructor, came to visit me. She noticed I was restless and preoccupied, and asked if I wanted her to see the baby before I was discharged. I nodded. She returned shortly and told me about the baby's condition. I found it difficult to concentrate on her words. Then she said, "When I walked into the room, the nurse was feeding another baby. I talked to her for awhile and then your son started to cry. The nurse smiled at him and went right over to the crib to see what was wrong." Only then was I able to leave the hospital in peacc.

#### Crisis intervention means good care

From my experience, I learned that crisis intervention following the birth of a defective child should include the elements of good nursing care. Remember, the parents will need you as much five days postpartum as they did immediately following the Arrange appropriate diversion for the mother during "feeding" times on the postpartum ward. Do not censure the parents' emotions but encourage them to elaborate on their feelings whenever they indicate they wish to do so. Do not expect the father to be a "pillar of strength" while the mother is in hospital. He will then just delay his reactions to the crisis until the mother gets home. Crisis intervention should include him, too.

The birth of a defective child is a traumatic event. The trauma experienced by the parents can be reduced or amplified by the nurse-parent interactions on the postpartum ward.<sup>2</sup> I was lucky. I had sensitive, empathetic nurses who helped me to cope by taking the time to stay with me when I needed them.

#### References

- 1. Scott, Diane W. Crisis intervention. In Current Concepts in Clinical Nursing, edited by Betty Bergersen et al. St. Louis, Mosby, 1967. p.392-9. (vol.1)
- 2. Von Schilling, Karin C. The birth of a defective child. Nurs. Forum 7:424-39, 1967.

## Do-it-yourself dialysis

Since regular maintenance dialysis for individuals with chronic renal failure began in 1960, the nursing role with these patients has increased. One of the greatest roles now is patient teaching. The author describes how patients are taught in a self-care dialysis center.

Elaine Schaffer, B.N.

Regular maintenance dialysis for individuals with chronic renal failure began in 1960. The nurse is no longer "just a nurse-technician" who monitors the machines; she is involved in total patient care and one of her greatest responsibilities is patient teaching.

Although hemodialysis cannot assume all the functions of healthy kidneys, it can give the person with chronic renal failure a chance for a useful life as breadwinner or homemaker. He or she is maintained on hemodialysis until a suitably matched kidney from a cadaver or in-family source can be transplanted.

Being on dialysis is by no means an easy life for the patient or his family. Each person in the family is affected, as life now revolves around the machine. The patient is dependent on the machine for his very existence; for 10 hours, 3 times a week, he must "hook up" and cleanse his blood of excess fluid and wastes. It is the dialysis nurse who helps the patient and family through the difficult adjustment period. Fear is one of the biggest factors hindering the patient in his adjustment to dialysis, and much of this fear stems from a lack of knowledge. It has been our experience that the person who can carry out his own dialysis independently is better adjusted to dialysis, is more confident and self-reliant, and often appears physically healthier than patients who are dialyzed in hospital.

Can a lay person learn the techniques and principles necessary to carry out his dialysis independently and safely? Our answer to this is: definitely, yes. Why would we want him to carry out dialysis independently? Our goal for all our dialysis patients is total rehabilitation. We want him to be as independent as possible, and the more he knows, the greater will be his independence and the better his rehabilitation.

Expansion of regular in-hospital hemodialysis programs is handicapped by shortage of money and staff. To overcome this, patients can be taught to undertake hemodialysis unattended, either at home or in a self-care dialysis center detached from the hospital. The chronic hemodialysis patient is not really ill enough to require hospital dialysis and, through our self-care dialysis program, we hope to move him from the hospital into a more homelike

Ms. Schaffer graduated from the University of Manitoba school of nursing in 1970. She has worked in the dialysis unit at the Health Sciences Center (Winnipeg General Hospital division) for three years. In the past year and a half, she has been coordinator of the home training program and the self-care dialysis center.

atmosphere, where he can assume total responsibility for his dialysis.

Since home dialysis is not always possible, the self-dialysis center is of great benefit in a province, such as Manitoba, where most of the population is centrally located rather than widely scattered throughout the province. The center is easily accessible to most persons. We have several patients living outside of the city and, where possible, we have sent these people home on dialysis. For the majority, the center is a "halfway house" between a hospital dialysis unit and home dialysis. It provides a safe, economical, and reliable method of treating and rehabilitating persons in end-stage renal

The Health Sciences Centre (Winnipeg General) self-care dialysis center, which opened on October 27, 1972, is in a building about one block from the hospital. Full capacity for the center is eight patients at one time. At present, the center is used for patient instruction in self-dialysis and for dialysis by the patient when instruction is completed.

The self-care dialysis center lessens the medical costs of dialysis treatments by requiring less nursing staff than the in-hospital dialysis unit and provides dialysis at lower costs than could be provided in the home be-

THE CANADIAN NURSE 29

cause of the availability of machines for multipatient use.

The center is staffed by two nurses only during the day, but it is open 24 hours a day, seven days a week for patient use. Persons learning self-dialysis must come during the day but anyone who has completed the course can adjust his dialysis time to fit in with his or her work schedule. Those who work during the day may dialyze overnight, as they require no nursing supervision. The unit is linked to the central hospital unit by phone.

Teaching program

The self-dialysis teaching program is approximately two to three months long and is adjusted to the individual patient and his learning ability. One person may require two months, while the next requires four months.

We have criteria for the selection of patients for self-dialysis. The patient should have no major, secondary, systemic disease that will interfere with the safety of his self-care. He should have an average intelligence and an ability to learn the skills and principles required. He must be fully aware of what self-dialysis entails and what is expected of him; knowing what the program involves, he and his family must have a positive motivation and a desire to carry out self-dialysis. No one who really wants to learn self-dialysis is refused and every effort is made to teach him and to assist him to learn as much as he can. At the same time, no one is forced into self-dialysis.

The patient is instructed in the technical aspects of dialysis: preparation and monitoring of all equipment, monitoring of vital signs, administering intravenous fluids while on dialysis, keeping accurate charts, and regulating heparin dosages. He or she is instructed in the theory of normal kidney function, kidney failure and hemodialysis, medications, and diet. Each patient learns normal laboratory blood levels and his own average levels. He checks his blood results and reads the reports. No information pertinent to medical management is withheld from him as he is a partner in the dialysis team.

The atmosphere at the center is easy going and friendly with a lot of kidding

between the patient and the nurse. A good sense of humor is an essential quality of the nurse at our center. The relaxed atmosphere minimizes stress and makes learning easier. The center is decorated by the patients and, as the population is predominantly male, a sparsely dressed Raquel Welch and pinups of Miss November and Miss December appear on the walls. It is in this relaxed environment that we teach our patients.

Most of the teaching is directed to the patient. Family members are included in the teaching program but ultimate responsibility for the dialysis lies with the patient. Family members learn to be capable assistants, particularly in emergency situations, but we do not feel the family member should have to assume major responsibility for the procedure. Most of our patients have taught their spouses to assist and, at the same time, each knows that he or she can manage his dialysis alone if necessary.

#### Teaching methods

We teach as much as possible by principle and discourage rote learning. The patient should always know the "why" behind his actions; he will be able to react to any dialysis problem safely on the basis of understanding. He is able to gain considerable confidence if he knows he can use reason rather than memory in facing a new situation.

Instruction is always done by the same nurse, who works closely with the patient. This encourages a comfortable relationship between the student-patient and the nurse-teacher and allows for consistency of instruction. As the program continues and the patient gains confidence, our dialysis technician joins the team for more teaching in depth about the inside workings of the machines.

The patient comes to our center before his dialysis regime is started. He becomes familiar with the area, meets the other patients at the center, and is introduced to the nurse and technician who will be working closely with him. If possible, he or she often brings the spouse or parent and together they adapt to what begins to feel like their "home away from home." As often as possible, we begin some theory classes at this time with the patient and family, as they will be more at ease and learning will be enhanced. An excessive level of anxiety, such as is encountered on the first dialysis, greatly hinders the patient's ability to learn. He is more receptive to new information during the weeks before dialysis is initiated or about two weeks after it has begun.

Instruction is assisted by several teaching aids. The most important one, the patients feel, is the dialysis manual. It includes both theory and procedures in language that a lay person can understand. The procedures are written in step-by-step detail that is easy to follow. The theory includes everything from normal and abnormal kidney function and hemodialysis to the action and side effects of the medications required. The manual is used diligently at first by each patient; as skill and understanding increase, it becomes a reference book for information lacking or forgotten.

As each topic is covered in class, the patient can refer to the subject in the manual and reread the information, adding to his understanding, possibly clarifying something, or raising questions

Visual aids are important to any teaching program; we use several dialysis films and slides. We have made our own "dialysis story" in slides and have the major workings of the dialysis system on slides. The latter are particularly good as pictures explain better than words. At present, we are preparing a teaching film to be made on videotape which, hopefully, will include the entire program. However, these aids will never replace the nurse and are only adjuncts to her teaching. The subject is always explained before being shown on a film or slide. If one relies too heavily on audiovisual aids, the program can become impersonal.

Practice equipment is available for the patient's use. Several patients have practiced preparing the dialyzer for use before they have begun a regular dialysis schedule. We also have available an "arterio-venous shunt arm" with which the patient is able to practice shunt dressings, initiating and discontinuing dialysis, and declotting of a shunt.

**JULY 1973** 



This young man is preparing to hook up for a dialysis treatment. He has an arterio-venous fistula in his right forearm; the enlarged veins are readily visible with the tourniquet applied. He has already inserted the needle that will return the blood from the dialyzer. The extension tube attached to this needle can be seen. Prior to inserting the needle that will carry the blood to the dialyzer, he is infiltrating the site for venipuncture with a local anesthetic, Xylocaine 1%.

Most patients have an internal arterio-venous (A-V) fistula rather than the external arterio-venous shunt to provide access to the blood stream; there are fewer restrictions for the patient with the fistula and less danger of clotting and infections. In the A-V fistula, a side-to-side anastomosis of the radial artery to an adjacent vein is made. The force and amount of arterial blood flowing through the fistula and returning to the venous circulation distends the blood vessels in the arm; the vessel walls thicken, making repeated venipunctures possible. Two punctures are required for each dialy-

sis, one to carry the blood from the patient to the dialyzer and the second to return the blood from the dialyzer to the patient. Large bore (14-gauge) needles are used for venipuncture.

Insertion of these 14-gauge needles is the most difficult thing for the patient to learn and is the most feared part of the treatment, whether the needles are inserted by the nurse or by the patient.

We have made practice veins, using tape and latex tubing; many patients practice with these at home before trying self-venipuncture. It is important that the patient learn venipuncture in steps, for example, first and most difficult, just inserting the needle through the skin; then threading it up the vein after the nurse has done the venipuncture; and then the actual venipuncture by himself, first on the largest available vein and then on the more difficult veins.

With practice, all our self-care patients become adept at inserting their own needles and they prefer to do this themselves. As one young patient said, "I can feel for the vein better than anyone and I know when to push and when not to. I would never have believed I could put those needles in but I'm glad I learned." A second patient has learned to insert the needles with his left hand. His fistula is in his right arm because of previous A-V shunts in his left arm, even though his right hand is dominant. Today he, too, is totally independent in his dialysis.

The dialysis nurse-teacher must prepare the patient to meet all potential dialysis problems. To accomplish this, we set up problem-solving situations and leave the patient alone to find the solution. For example, we have placed a blown fuse in the machine or caused an intentional air leak in the drip chamber of the blood tubing. The patient learns best when placed in the actual situation.

As long as the patient knows the nurse will not allow him to make any harmful mistakes, he will learn. What happens when one forgets to release a clamp on the exit or venous end of the dialyzer but continues to pump blood through from the arterial side? One of our patients found out. Blood shot out from all sides of the dialyzer. Such a mess, no one could forget.

A second patient also learned the hard way. He frequently forgot to clamp his blood lines before cutting the tape bridging the connection between the needle and blood line; the connection can come apart when the tape is cut. One evening he forgot, as usual. The connection accidently pulled apart and blood spurted out in all directions. He could have lost considerable blood if the nurse had not manually pinched the tubing. He is now home on dialysis and no one needs to remind him of those clamps.

The nurse often finds it difficult to

THE CANADIAN NURSE 31

allow the patient to manage by himself. It is not easy to watch him lose excessive fluid and become hypotensive, and not rush in to help him. But the nurse may not be there the next time this happens. One of our patients was particularly prone to excessive fluid loss; I was afraid to leave him alone, but I knew he would be going home on dialysis. One day I left him alone for two hours and, when I returned, he was sitting in a chair reading a magazine. "How is your blood pressure?" I asked. "Fine," he replied. There was a long pause before he added -- "but it was 60/20 about one hour ago — I guess I did it again — but I got out of it alone." From then on I never worried about leaving him alone.

#### Patients become responsible

The patients want to learn, and they want the responsibility and independence that can be theirs. One nephreetomized patient occasionally has dificulty maintaining his "dry" (ideal, with no excess fluid present) weight; he is young and enjoys parties, at which he sometimes overindulges, even though he knows the consequences. About two months ago, his weight steadily rose to a maximum of about 7 kg. over his ideal "dry" weight. His blood pressures were elevated and he was getting short of breath. He knew he would have to do something and, without anyone telling him what to do, he decided to have extra dialysis. For four out of the next five nights he hooked up to his machine.

He dialyzed close to 50 hours that week and lost all 7 kg. "I knew the weight had to come off and I knew how to take it off, but I don't know if you could have forced me into 50 hours of dialysis in one week, a year ago. I understand what is happening now; I am responsible for what happens to me, not the nurses."

The patients at the center have developed a comradeship and they help each other during the dialysis treatments. One of the patients, who had just completed the self-dialysis course, wanted to come on a Sunday for her dialysis but was still fearful of being alone at the center. The center is not staffed on weekends and there were no other patients dialyzing on Sundays. A second patient volunteered to come in for an extra dialysis that Sunday, to be with her in ease she needed assistance. "The extra dialysis wouldn't hurt me anyway."

As the patient becomes more adept in performing technical procedures and develops confidence in his abilities, he begins to add variations to the procedures. He often teases his nurse-teacher and may eriticize some of her techniques. Many procedures have been revised because the patient found a more efficient way.

We encourage this resourcefulness and accept the criticism without feeling threatened by it. The patient may become more skilled than the nurse in some procedures; this shows her teaching was successful. The atmosphere we have tried to create in the center encourages the patient to express his feelings, his likes, his dislikes. The nurse and the patient become good friends and are able to speak with each other freely, openly, and honestly.

The nurses at the center have tried to help each patient realize his, or her, eapabilities. He may become a dialysis expert but it is the nurse who has guided him there, and this makes self-dialysis teaching rewarding.

#### **Bibliography**

Gutch, C.F. and Martha H. Stoner. Review of hemodialysis for nurses and dialysis personnel. St. Louis, Mosby, 1971.

Hampers, Constantine L. and Eugene Schupak, Long term hemodialysis; the management of the patient with chronic renal failure. New York, Grune and Stratton, 1967.

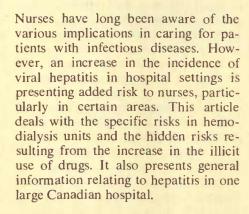
Hewitt, Helon. Developing a therapeutic nurse-patient relationship. In Symposium for Nurses Specializing in Artificial Kidney Therapy, Atlantic City, 1969. A dialysis symposium for nurses, Washington, U.S. Department of Health, Education, and Welfare, 1969. p.3-7.

Schlotter, Lowanna. Let's really teach our dialysis patients. In Symposium for Nurses Specializing in Artificial Kidney Therapy, Atlantic City, 1969. A dialysis symposium for nurses, Washington, U.S. Department of Health, Education and Welfare, 1969. p.35-9.

## Viral hepatitis — a risk to nurses

Viral hepatitis is a serious threat to personnel who work in various areas of health-care institutions. Every nurse must be aware of the risk to herself and to patients, and take all possible precautions to prevent the transmission of this potentially fatal disease.

#### **Christine Frye**



Viral hepatitis

Viral hepatitis, generally classed as infectious (type A) and serum (type B) hepatitis, is a disease characterized by

random necrosis of liver cells. Infectious hepatitis may be prevented, or its severity lessened, by injections of immune serum globulin. Its incubation period is from two to six weeks. On the other hand, serum hepatitis does not appear to be preventable by immune globulin, and its incubation period is from four to twenty-three weeks.

Transmission of the virus is usually fecal-oral in infectious hepatitis, and parenteral in serum hepatitis. However, an unqualified distinction between the two types is difficult.

Hepatitis is first manifested in flulike symptoms: lassitude, weakness, drowsiness, anorexia, nausea, abdominal discomfort, fever, and headache. Jaundice may develop, lasting about two weeks, and may be accompanied by dark urine, gray stools, and mild pruritus.

An enlarged and tender liver is the usual physical finding. Splenomegaly, posterior cervical adenopathy, and "spider" angiomas may be seen. However, for every clinical case of hepatitis, there may be several asymptomatic or mild subclinical cases, usually undetected.

The most valuable laboratory test in

Christine Frye, a graduate of the Mary Fletcher Hospital School of Nursing in Vermont, is Head Nurse in the Hemodialysis Unit of the Ottawa Civic Hospital. She is President of the Canadian Society of Extracorporeal Circulation Technicians, a Certified Perfusionist, and a member of the editorial board of *ThelLe Journal* (CanSECT). She expresses thanks to Norma Rocheleau for her assistance in preparing this manuscript.



diagnosing hepatitis is serum transaminase (SGOT, SGPT). A rise in SGOT can be expected several days before the appearance of physical symptoms or jaundice. SGPT remains abnormal longer than SGOT, usually up to 90 days. Serum bilirubin and alkaline phosphatase levels may be slightly elevated. The current use of Australia antigen determination is discussed later in this article.

There are several ways to prevent the transmission of the disease, aside from isolation of the patient. Unnecessary use of blood and blood products should be avoided, since every unit is a potential carrier of the virus. The use of disposable syringes and needles is becoming more common in hospitals, and careful handling of their disposal is essential. Related to this is the need to educate the public, particularly drug abusers, on the dangers of unsterilized needles and syringes.

Careful handling, meticulous autoclaving, and protected disposal of contaminated equipment in laboratories, blood banks, operating rooms, and dialysis units should not be neglected. Care must be taken to avoid parenteral or oral contact with contaminated material.

In 1963 an unusual antibody was found in the serum of a hemophiliac patient who had received many transfusions. This antibody was found to react with the serum of an Australian aborigine, but not with the sera from a variety of other people. The antigen to this antibody was thus labeled Australia antigen (Au (1)).

Some time later, researchers in Japan found Au(1) in the serum of 20 percent of patients with viral hepatitis. Although evidence of association between Au(1) and hepatitis does not prove a causal relationship, research following this discovery has led to the conclusion that Au(1) is a significant factor in hepatitis. It may be found in the blood early in the disease, often before the

appearance of any symptoms.

The antigen, as seen under the electron microscope, is a spherical particle about 200 A in diameter. No one has yet been able to grow it in culture. It is now believed that the antigen forms a protective coat around the hepatitis B virus. It survives cold (to 1°C), heat (to 60°C), boiling for three minutes, and many bacteriocidal agents.

The Australia antigen can be transmitted through urine, feces, emesis, and wound discharge, but is 1,000 times more transmissable through blood. As 90 percent of serum hepatitis patients carry Au(1), its presence is considered indicative of the disease.<sup>2</sup> Because of this relationship, Au(1) is now being called hepatitis B antigen (HBAg). Since Au(1) (HBAg) is apparently not the infective agent, antibody formation does not guarantee immunity against serum hepatitis.

Screening of all donor blood is recommended to prevent transfusion of antigen-carrying blood. However, present screening techniques are not 100 percent effective. Testing for the presence of HBAg is now commonly done in many areas of potential hepatitis, such as transfusion services, hemodialysis units, and in cases of suspected parenteral drug abuse.

#### Hemodialysis-associated hepatitis

As the patient's blood passes through a membrane circuit during hemodialysis, there is an exchange of water and ions between the blood and a chemical "bath" solution circulating around it. In this way, metabolic waste products, excessive electrolytes, or toxins pass from a high concentration in the blood, through the membrane, and into the low concentration in the bath. Although the blood is completely enclosed, hemodialysis personnel can have manual contact with it while connecting and disconnecting the patient and tubings, when there is a leak in the membranes, or while cleaning the equipment

after the dialysis.

In a comprehensive report from Edinburgh, five factors are listed as means of exposure:

1. the transfusion, during dialysis, of infected blood, plasma, or blood products (other than immune globulin); 2. admission to the chronic dialysis program of a hepatitis carrier; 3. the infection of chronic dialysis patients outside the unit, (for example, during surgery requiring blood; while self-administering drugs); 4. transplantation from an infected donor; and 5. spread to patients from staff who are chronic or short-term carriers. (However, in most outbreaks, hepatitis in staff follows, rather than precedes, infection in patients.)<sup>3</sup>

Other factors contributing to the possibility of epidemics are the small, congested areas often used for dialysis units, the close contact between patients and staff, and the sharing of equipment by patients. These patients are also prone to infections, frequently subclinical, and asymptomatic hepatitis may not be detected. Common sense should preclude such factors as putting both blood and food in the same refrigerator, or poor hand-washing techniques.

Danger to the staff results primarily from direct contact with contaminated material. After manual contact with blood or excreta, hand-to-mouth activities allow oral ingestion of the virus. Any skin lesion is a potential site of entry. Accidental needle punctures or skin cuts are probably the most serious hazard, even through protective gloves.

Many papers have been published concerning hepatitis in dialysis units, some reporting deaths of both patients and staff members. As early as 1970, one source reported the incidence of cases in the United States. 4 In the period from the mid-1960s to July 1969, 83 of 125 dialysis centers (66 percent) reported 349 cases of hepatitis among dialysis patients and staff (mostly nurses).

This sample of reported cases may have grossly underestimated the actual incidence of dialysis-related hepatitis, because many subclinical cases went undetected, and the report was voluntary.

Recently, a Canadian journal reported an epidemic of hepatitis in a Montreal hemodialysis unit.<sup>5</sup> There were 54 people at risk in the unit: 24 patients, 17 full-time staff, and 13 part-time staff. The unit contains 10 beds, each in a separate, walled cubicle, and 10 artificial kidney machines in an open central area.

Of the 54 people, 10 patients and 10 staff members developed hepatitis. Seven of the staff members traced their exposure to accidental needle punctures and one to a scratched hand. However, two cases developed in electricians who had merely repaired equipment in the unit. The source of infection in the 10 patients was not determined.

Australian antigen was present in the serum of four staff members and seven patients, and remained positive up to a year in the patients. Liver function tests stabilized and improved more quickly in patients than in staff. The only cases that required hospitalization were three of the staff. Neither positive HBAg nor clinical hepatitis was seen in any relatives of patients or staff. No deaths were reported.

As the epidemic developed, certain policies and procedures were instituted to reduce the chances of further spread, including precaution techniques. The frequency of blood transfusions was sharply reduced, from 204 transfusions in a three-month period before the epidemic to 43 in the three months after the outbreak of the epidemic.\* Admission of new patients to the dialysis program was limited as much as possible during the epidemic.

In April 1973, in another Canadian dialysis unit I know of, 6 of 11 patients were found to have HBAg in their

sera, but none had abnormal liver function tests or overt symptoms of hepatitis. In this unit, the nurses are tested monthly for liver function and HBAg; four of seven have been found to have antibodies to HBAg.

Precautions include use of disposable gloves when handling any bloodcontaminated equipment; careful hand-washing; a ban on eating, drinking, and smoking (by staff) in the unit; clear marking of all lab requisitions accompanying HBAg positive blood; and careful bagging of all soiled dressings and linen. Since the HBAg particle is small enough to pass through imperfections in the dialysis membrane, there is always a risk of transmission from patient to patient through shared equipment.6 Fortunately, at the time of writing, there has not been an outbreak of clinical hepatitis in this busy, crowded unit.

**Drug-associated** hepatitis

"The association of viral hepatitis with contaminated injection equipment shared by drug users is well known. Shared needles were first implicated as a source of hepatitis in drug addicts in New York City in the late 1940s and early 1950s."7 Analysis has shown marked changes in epidemiologic characteristics of reported viral hepatitis in the years 1966-1971 in the United States, including seasonal, regional, and age fluctuations. "These changes, along with a gradual but dramatic increase in reported annual incidence of viral hepatitis during the last six years, have occured simultaneously with an emerging nationwide epidemic of illicit parenteral use of drugs."8

From July 1970 to July 1971, 11,738 cases of viral hepatitis were reported in the 15- to 24-year age range in 49 states, excluding California. Thirty-

one percent of these patients (3,993) either admitted to, or were suspected of, drug use. The authors comment, "It is quite likely that many patients with drug-associated hepatitis deny illicit use of needles and that these data [such as quoted above], although impressive, greatly underestimate the true magnitude of the problem." They conclude that "drug-associated hepatitis is not an isolated incident or a local problem, but a nationwide epidemic."

Another American report describes a 42-month evaluation of 7,272 presumably well adolescent users of heroin, sedatives, and airplane glue. <sup>10</sup> Thirty-seven percent were found to have abnormalities in liver function, most commonly elevated SGPT. Most used intravenous or subcutaneous heroin, and all sedative users had previously taken heroin. Use of amphetamines and sedatives increased during the study period, while glue sniffing decreased.

Of the 4,052 heroin users, 129 had clinical evidence of acute hepatitis within the first month of observation. Two died, and postmortem examination revealed massive acute hepatic necrosis in both. Frequently, liver disease was not clinically apparent, and a diagnosis of hepatic dysfunction was based on the findings of chemical abnormalities of liver function.

Australia antigen determination was performed in only 46 of the 129 clinically ill adolescents in this American study. The sera of 11 were positive in the acute phase of illness. Australia antigen determination was performed on the serum of all drug users during a five-month interval within the study period. Routine screening of sera from 80 consecutive heroin users revealed 39 with HBAg and 6 others with the antibody. The antigen was found in approximately one-half of the asymptomatic patients with abnormal liver function tests.

A dramatic case of drug-associated hepatitis was treated at the Ottawa

<sup>\*</sup>Both figures were for 24 patients.

Civic Hospital in 1972. A 19-year-old female student was transferred from another hospital, where she had been admitted with a mild illness.

On admission to the Civic Hospital, she was unconscious and grossly jaundiced, and the admitting diagnosis was fulminating type B viral hepatitis with hepatic encephalopathy. Serum electrolytes were relatively normal, and her renal function appeared adequate. However, all liver function tests were grossly abnormal, and HBAg was reported positive.

This student had a history of intravenous injection of amphetamines for at least one year, and the use of methadone and LSD was suspected. On admission, her blood amphetamine level was 24 mg. percent, classed as "extremely high" by the hospital labo-

ratory.

As amphetamines have been reported to be at least somewhat dialyzable, 11 an emergency hemodialysis was started, using portable equipment in the isolation ward. Dialysis, combined with exchange transfusions and fresh frozen plasma, was continued for 11 hours, with little evidence of clinical improvement. The patient remained unconscious, but was extremely restless at times.

Her condition gradually deteriorated, over the next two days, with a temperature elevation to 40°C and repeated convulsions, terminating in death. The cause of death was listed as "acute massive hepatic necrosis due to serum hepatitis (apparently resulting from injection of contaminated materials, likely self-administered)."

#### General hospital problems

Dorothy Pequegnat is the infection control officer at the Ottawa Civic Hospital. When I interviewed her, she gave me greater insight into the problem and the handling of viral hepatitis in the hospital setting. She teaches the nursing staff to be alert to the type of patient who might be a hepatitis carrier, and to treat blood, excreta, and wound discharges from these patients as dangerous.

All patients with hepatitis are treated the same until the HBAg result is reported; if positive, this is considered diagnostic of serum hepatitis. Any

jaudiced patient admitted is put on bedpan precautions until a diagnosis is made. If hepatitis is diagnosed, complete enteric and needle precautions are continued for 10 days following the onset of jaundice. (It should be noted that patient serum can remain infective for a variable period of time.)

The risk of hospital spread of the disease is increased by the number of drug-associated hepatitis patients who are admitted for social, rather than medical, reasons. That is to say, they need rest, nourishing food, and cleanliness more than medication and nursing care. Therefore, increasing numbers of "street people" are being admitted to hospitals, even with mild cases of hepatitis.

Three areas of nursing practice, aside from hemodialysis and the isolation ward, carry a particular risk. One is the operating room, as many unsuspected hepatitis carriers undergo surgery. Staff may cut or prick their fingers, and contact with blood is almost constant. Our hospital's policy is to avoid surgery if at all possible on suspected carriers, such as known drug users, until an HBAg determination is reported. This may preclude kidney transplantation for waiting dialysis patients who are HBAg positive.

A similar problem arises in obstetrics, where there is contact with blood and vaginal discharge. Also, HBAg crosses the placental barrier, and there is danger of liver damage in the fetus. This raises the question of the advisability of screening all pregnant women for HBAg.

A third group at risk is the nurse technician team that does essentially all venipunctures in the hospital. They are screened monthly for liver function abnormalities and HBAg, and one member of the team developed serum hepatitis. She was unable to remember any needle prick with known positive blood.

A previously quoted report lists other areas of risk in hospitals:

- the admission of positive dialysis patients to general medical or surgical wards without warning the staff of the risk;
- □ autopsies performed on undiagnosed cases;

- □ handling of contaminated specimens by laboratory personnel;
- research, particularly tissue typing and biopsying of transplanted organs; and
- handling of poorly packaged linen and garbage by laundry and maintenance personnel. 12

#### Summary

Viral hepatitis is a serious threat to personnel working in many areas of health-care institutions. Awareness of the relationship of HBAg to hepatitis is increasing and may eventually lead to the development of an effective immunization technique. In the meantime, however, every nurse must be aware of the risk to herself and to patients through her. She must take all possible precautions to prevent the transmission of this potentially fatal disease.

#### References

- Phillips Donald F. Hepatitis Part
   The scientific advances. *Hospitals:* J.A.H.A. 45:1:48-54, Jan. 1, 1971.
- 2. Posen, G.A. Personal communication to the author.
- Marmion, B.P. and Tonkin, R.W. Control of hepatitis in dialysis units. Br. Med. Bull. 28:2:169-79, May 1972.
- Center for Disease Control. Progress report: prevention and control of hemodialysis-associated hepatitis. Atlanta, Sept. 1970.
- Pepin, N. et al. Hépatite épidémique chcz les hémodialyses chroniques en milieu hospitalier. The Le Journal 1:1:16-8, Dec. 1972.
- 6. Blumberg, B.S. et al. Australia antigen and hepatitis. *New Eng. J. Med.* 283:349-54, Aug. 13, 1970.
- 7. Garibaldi, R.A. et al. Impact of illicit drug-associated hepatitis on viral hepatitis morbidity reports in the United States. *J. Infect. Dis.* 126:3: 288-93, Sept. 1972.
- 8. Ibid.
- 9. Ibid.
- Litt, 1.F. et al. Liver disease in the drug-using adolescent. J. Pediatr. 81:238-42, Aug. 1972.
- 11. Maher, J.F. and Schreiner, G.E. Current status of dialysis of poisons and drugs. *Trans. Amer. Soc. Artif. Intern. Organs.* 15:461-77, 1969.
- 12. Marmion, B.P., op. cit.

## How to make microbiology interesting for students

When students become involved in choosing their own projects, carrying them out, and evaluating them, a course in microbiology can be meaningful and even fun.

Joe Anne Murray, B.Sc., B.Ed., M.S.

How often as students have we complained about the irrelevancy of this course or that course forced on us by well-intentioned faculty? How often as teachers have these same complaints been addressed to us by our students? As the faculty science coordinator at the Peter Bent Brigham Hospital school of nursing, I am no longer the "student complainant"; I am the "teacher recipient."

One of the many responsibilities of my position is teaching the physical sciences - anatomy, physiology, and microbiology — and, at the same time, explaining their need in the curriculum. The major problem has been with the microbiology course offered in the first term of the freshman year.

"Just what has this course got to do with nursing?" "I can't pronounce Pseudomonas aeuroginosa, let alone spell it." "Is it really worth the effort?"

To the new nursing student, who is unfamiliar and uneasy in the clinical area, the usual explanations fall on deaf ears. After discussing this problem with some of my colleagues and reflect-

ing on the course objectives and expected behavioral outcomes, we decided to use another approach to bring microbiology to life and to make it a meaningful learning experience for the stu-

The purpose of this article is to share the experience with you, not to propose a startling innovation in the art of teaching.

Along with the required theoretical and laboratory course content, the students involved themselves in a project of their own choosing that was in some way related to microbiology. They grouped themselves from within their laboratory sections; the maximum number in each group was six.

Once the groups were arranged and the subject matter chosen, the students gave me various dates for the presentation of their projects, which would occur during the laboratory periods. We agreed the projects would be evaluated by the students and the ins-

The evaluation tool, including a grading scale, was devised with the areas for appraisal designated as:

- evidence of research into the subject matter;
- organization of the material into logical sequences;
- evidence indicating adequate knowledge of the subject matter;
- presentation of the material, including

The author is a graduate of St. Francis Xavier University, Antigonish, Nova Scotia, and Boston College, Massachusetts. She is presently science coordinator at the Peter Bent Brigham Hospital School of Nursing, Boston, Massachusetts.

manner of delivery; minimum use of props, notes, and so on; use of audiovisual aids; and effective use of group members.

Each member of the group would receive the same grade, and this would count as a quiz to be averaged with other quizzes, mid-term examination, and final examination.

#### Projects "ran the gamut"

The subject matter for the projects ran the gamut from infection control in the hospital to the investigation of sanitary conditions in restaurants. In all, there were 18 presentations, most of which were very good. The students prepared their own charts, cultures, and slides for microscopic examination. They had slides made, showed films, and demonstrated the use of specific equipment; in addition, they distributed literature, photographs, and arranged for guest speakers.

We learned how an industrial plant prevents the introduction of microbes into its products. The most recent film on venereal disease was presented, along with some excellent slides. We saw the inside of some sanitary and some not so sanitary restaurant kitchens through photographs and slides taken by the students.

Three enterprising young ladies decided to check out an advertisement displayed by a local supermarket, which claimed the store was trying to produce conditions that would achieve a goal of "zero microbial population growth." Their findings, which included a tour of the facility with the microbiologist from the city, cultures taken from specific areas in the meat-cutting department, and testing of a special disinfectant used by the employees, proved that the supermarket was living up to its advertisement.

After investigating methods used to control food spoilage at one of the highly rated restaurants in the area, the students were treated to a nice dinner.

One group of students, with assistance from the surgical bacteriology laboratory of a hospital, conducted a complete bacteriological survey of the physical therapy department. At the time of the sampling, two patients were

receiving therapy and three to four therapists were in and out of the area. Standard procedures of volumetric air sampling, settling plates, Rodac contact plates, and floor swabs were employed. Water samples were taken from hydrotherapy equipment and were filtered, using the Milipore technique to recover water organisms. The students exhibited the equipment, explained how it was used, and reported the outcome of the survey. The results were published and sent to various department heads in the hospital.

#### **Evaluation**

Some of the following comments were expressed by students on an evaluation questionnaire at the end of the term.

"The projects were fun to do and interesting."

"I can see how microbiology relates to nursing in many ways."

"The kitchen in my apartment will be cleaner from now on!"

"We worked as a team; we got involved."

It was fun, and the projects did bring the microbiology course closer to home. They promoted interest, encouraged initiative, and stimulated critical thinking. The nursing measures and aseptic techniques practiced in the clinical area became meaningful and important. The course for these students had achieved a degree of relevancy. One added note of interest to the teacher was that not one student complained about the grade she received.

It is difficult to evaluate the long-range effectiveness of this or any other approach to learning in a specific subject. The immediate goals, as shown by the students' response, were realized. The attitude of these students toward the course was more favorable than that of any previous group of students. This in itself is incentive enough for me to continue the projects or similar experiences along with the conventional methods of lecture and laboratory for the microbiology course.

### in a capsule

Glass is the culprit

In a letter to the editor of the Journal of the American Medical Association (Jan. 29, 1973), two physicians comment about oral ingestion of mercury from broken thermometers. Their remarks are interesting.

"Each year, our Poison Control Center receives 20 to 25 calls from anxious parents whose children have bitten and broken thermometers and

ingested the mercury.

"In regard to mercury orally ingested, we would like to make a few points

of significance.

"I. Thermometers contain metallic mercury, which oxidizes too slowly in the intestinal tract to yield the mercury ion for absorption and is, therefore, not a hazard. In the past ten years, we have encountered no toxicity from this source of mercury. A small danger may exist from the broken glass.

"2. Parents should be advised not to use oral thermometers in children because of the hazard of broken glass."

Movies by the mile

Secondary school students in northern Ontario put their imagination to work and solved the problem of boredom that would normally accompany a two-hour bus ride to school each day.

In its March 1973 issue, *Ontario Traffic Safety* described the Sudbury students' project of installing film and tape equipment on the bus, which makes the long trip interesting.

"Each double seat is equipped with two sets of earphones, which receive the sound for both the forms and the taped music that is playe. The students... worked out all the technical aspects, from the projector at the back of the bus powered by a motor outside the bus, to the daylight screen and window shades needed for a clear picture."

There were some bugs in the equipment, but these were worked out. Robert Bradley, Sudbury's superintendent of schools who encouraged the students, explained: "With a rough road containing more potholes than tar, it wasn't surprising that the projector disintegrated after the first three weeks. There wasn't a screw left in it. The students tried soldering them in. They just broke. Now they've devised a floating pad so the projector 'gives' a little with the jolts of the bus, and it's working fine."

Good way to help the handicapped

An excellent example of a way to help the handicapped comes from Ottawa. The Rehabilitation Institute of Ottawa and the National Capital Commission have compiled a bilingual guidebook that describes public buildings in Ottawa in terms of their accessibility to handicapped persons.

Information in Ottawa — A Guide for the Handicapped is based on a survey by volunteers, who visited more than 300 buildings to find out if they could be used by aged and handicapped persons, especially those in wheelchairs.

The survey also attempted to create awareness of the architectural barriers that prevent the handicapped from using public buildings and to encourage both the modification of existing buildings and the elimination of barriers in future buildings.

Buildings described in the guidebook include apartments, hotels, churches, theaters, hospitals and medical facilities, banks, beauty salons and barber shops, office buildings, funeral parlors, museums and art galleries, libraries, parks and other recreational facilities, schools, restaurants, stores, and transportation facilities.

This guide, which is free of charge, gives information such as the number of steps at the entrance of the building, the width of the doorways, whether elevators are available, the location of washrooms, and the provision of handrails on stairways. Buildings not accessible to the handicapped without assistance are listed so arrangements for help can be made in advance.

Copies of the guide are available from several sources, including the Ottawa Handicapped Society, 84 Sterling Ave., and Canada's Capital Visitors' and Convention Bureau Inc., 251 Laurier Ave., W., Ottawa.



"Would that blood pressure still be alright if I happened to be a little older than thirty?"

### books

A Commonsense Approach to Coronary Care: A Program by Marielle Ortiz Vinsant, Martha I. Spence, and Dianne E. Chapell. 222 pages. St. Louis, Mosby, 1972.

Reviewed by Lorene Bard Freeman, Lecturer, School of Nursing, Queen's University, Kingston, Ontario.

The programmed format is used to provide a stimulating, self-teaching aid and a systematic basis for problem solving with the coronary patient. The book is directed particularly to the nurse, the student, and all levels of practitioner.

Based on a thorough knowledge of normal anatomy and physiology, the text concentrates on major problems associated with an acute myocardial infarct and makes no attempt to deal with all aspects of coronary artery disease

Thus, on completion of this program, one could expect to have a working knowledge of: heart anatomy, basic electrophysiology, and chemical imbalances; history and diagnostic tests associated with an acute myocardial infarct; complications: arrhythmias (including heart block), intraventricular (bundle branch) conduction disturbances, heart failure, and shock; drug therapy in the management of arrhythmias, heart failure, and shock; electrical intervention in the management of cardiac arrhythmias: countershock and pacemakers; and arrhythmias with abnormal ORS complexes: fusion, aberration, and atrioventricular dissociation.

Most of the foregoing items include a brief but fairly comprehensive list of related nursing orders.

The programmed method moves in a logical progression by stages gradual enough for the beginning student or practitioner to grasp; the objectives of the text as outlined by the authors are met.

Regrettably, however, some of the most important areas of nursing the coronary patient are omitted, mainly the psychological and rehabilitative aspects. The authors felt the programmed format did not accomodate this content.

Emotional factors play a major role in influencing heart action. Recent

studies have indicated that the way in which the patient learned to cope with his feeling about his heart attack has affected his chances for recovery and rehabilitation. The nurse must accept the responsibility of providing comfort as well as physical safety. She needs to be taught the principles and rationale of supportive interpersonal relationships and the successful use of defense mechanisms and other ego strengths to help the patient adapt to the loss or change of functioning, prestige, income, and so on. This, I feel, would fit the design of a programmed text and more nearly complete the learning needs of the reader.

Despite the omissions, the book would be an asset to nurses and nurse educators. The reference lists, as well, would be useful for those wishing to pursue areas of particular interest.

Pathology by C.P. Mayers. 165 pages. London, England, English Universities Press, 1972. Canadian Agent: Musson, Don Mills, Ont.

Reviewed by Jo-Ann Tippett Fox, Assistant Professor of Nursing, Dalhousie University, Halifax, N.S.

This volume is one of a series of 11 paperbacks prepared in Great Britain, which "cover the syllabus of training of the General Nursing Council." The author explains that he based his topics partly on the examination requirements of nursing councils in Great Britain, Canada, and Australia and partly on personal experience.

The first half of the book examines general disease processes in a simplified fashion. This oversimplification leads to omissions, particularly in the discussion of the role of potassium; no mention is made of the systemic effects of hyperkalemia, its seriousness, and the disease entities where it is likely to occur. The chapter on cancer is brief but more comprehensive.

A separate chapter is devoted to most of the body system but, as the author states, the topics of obstetrics and gynecology, psychology and psychiatry, and neurology are not discussed, since these are the topics of other volumes in the series.

The major pathological conditions of each of the remaining systems are dealt with simply and briefly with occasional

simplified diagrams. One of the mechanical comparisons has a truly Scot's flavor (the author lives in Edinburgh). I had never thought of the analogy of the functioning of the bagpipes and the human heart and, since I know more about the heart than the bagpipes, this comparison served to enlighten me on the names and functions of the bagpipe parts.

This text has no further reading lists or bibliography. Therefore, I feel it would function only as an introductory text and would have to be supplemented in most programs by a comprehensive reading list or a further text.

Venereal Diseases: Treatment and Nursing by Hazel Elliott and Kurt Ryz. 115 pages. London, England, Baillière Tindall, 1972.

Reviewed by P.Y. Abraham, Assistant Professor, School of Nursing, University of Windsor, Windsor, Ontario.

A problem associated with sexually transmitted "dis-ease" is the condemnation of the individual because he has violated the "sacredness" of sex and is rightfully punished. These attitudes still prevail in society. Such attitudes seem to blind society to seeing venereal diseases (VD) in a medical light and compounds the problem by passing a moral judgment on "those people." Health professionals are part of the society and not immune to the value systems of the community. Probably this is why the authors discuss the desired qualities of a nurse who works in a VD clinic.

Statistics show that the incidence rate in VD is rising. Related psychological and social problems for the individual and society will also surface. Chapter two points out some of these problems and the ways a nurse can ease the situation.

The discussion of male and female anatomy of the genitourinary system is kept simple, while pointing out some of the frequent entry points of the causative organisms for the sexually transmitted diseases.

Syphilis and gonorrhea, which are the most serious and frequent infections among VD, are discussed in some detail;

#### books

an up-to-date account of the signs and symptoms of the diseases and the recommended treatments for them are given.

The authors also have given a brief account of other conditions that are usually transmitted through intimate contact.

This book is short, readable, and gives accurate information on sexually transmitted diseases. It will serve as a quick reference for those who are interested and want to be informed about these "dis-eases."

Moral Dilemmas in Medicine by Alastair V. Campbell. 214 pages. London, England, Churchill Livingstone, 1972. Canadian Agent: Longmans, Don Mills, Ontario.

Reviewed by Ina Watson, Assistant Professor, School of Nursing, University of Saskatchewan, Saskatoon, Saskatchewan.

Doctors and nurses are faced with many moral dilemmas in their practice today. The author has written this book to provide a short introduction to some of the major theories of moral philosophy and to relate these to contemporary moral problems in medical care. He is well qualified to write such a book, as he has been lecturer in Christian Ethics, University of Edinburgh, and lecturer in ethics, R.C.N. Institute of Advanced Nursing Education (Scotland).

The objective of the book is well achieved. The content is built around examining four theories as possible answers to the question: "What constitutes the foundation of morality?" Theories based on conscience, the common good, moral law, and respect for persons are discussed. Limitations of each theory are brought out. Contemporary issues, such as abortion, human experimentation, organ transplantation, and the dying patient, are examined. The conclusion drawn from this discussion is that there are no set answers — no agreed conclusions.

This is an interesting and timely book. It would be excellent reading for any person in the health sciences or, indeed, for the layman. It would help people to attain a perspective on abortion, human experimentation, organ transplantation, and death. The right of the fetus as well as the mother is discussed.

Issues involving donor and recipient of organ transplants are examined. The propriety of telling the patient the IULY 1973

truth about his prognosis and the need for trust, which is transgressed if the patient is lied to, is illustrated.

One strong point of the book is the use of authentic examples as each theory or issue is discussed. Another is that no dogmatic answers are provided; indeed, no answers are provided. Guidelines are given to help each person find his own answer to the moral dilemmas he may be faced with in the practice of medicine or nursing.

Alexander's Care of the Patient in Surgery, 5ed., by Walter F. Ballinger Jacquelyn C. Treybal, and Ann B. Vose. 905 pages. St. Louis, Mosby, 1972.

Reviewed by Pat Derham, Inservice Instructor, Operating Room, St. Boniface General Hospital, Winnipeg, Manitoba.

This text is an excellent teaching tool for OR orientation and training programs, and is a good reference for senior OR staff and surgical ward nursing personnel. It deals primarily with the technical aspects of OR nursing and surgical procedures. However, this new edition does approach the care of the patient in surgery in a more patient-centered and humanistic manner. Psychological and physical care of the surgical patient is stressed in more depth than was previously done.

The text is well organized, and written material is supplemented by means of excellent diagrams and illustrations that facilitate understanding of operative procedures. Despite the amount of material covered and the number of contributing authors, there is relatively little duplication in content.

The first two chapters deal briefly with the concerns involved in the design and administration of an operating room. This section emphasizes physical safety features and the need for standards of practice to facilitate provision

of quality nursing care.

In the next five chapters, the fundamental skills and knowledge in relation to OR technique and patient care are well outlined. The information given is brief and concise, principle-oriented where possible, and lends itself easily to use as a quick reference or a stimulant for study in more depth. Discussion of skin preparation soaps, other than the strictly controlled hexachlorophene compounds, is completely lacking. Greater emphasis could have been placed on electrical hazards in the OR, which are an increasing concern in surgery.

The remaining chapters are organized into sections dealing with body systems, specific organs, or specialty surgery. This method lends itself to

quick location of material. The introduction to each chapter includes a brief outline of anatomy and physiology; nursing considerations and basic instrument requirements, specific to the area of concern, are discussed. Operative procedures are considered in relation to definition, reasons for surgery, setup, and preparation of the patient, followed by a step-by-step description of the surgical technique.

The discussion presumes a knowledge of anatomy greater than that described in the text, which tends to stimulate research and review on the part of the reader. These chapters provide the opportunity for the OR and ward staff to understand surgical techniques and to relate these to individual-

ized nursing care.

The new additions in this text are most welcome. Outdated procedures have been eliminated; modern techniques, such as microneurosurgery, have been added. Cesarean sections, angiography, and techniques related to outpatient programs, previously omitted, are now included.

There are two completely new chapters in the text. Reconstructive plastic surgery deals with the various traumatic, congenital, and disease-produced deformities and their surgical treatment. Pediatric surgery considers the anatomical and physiological differences inherent in the infant as opposed to the adult surgical patient. Common operative procedures performed in this age group are well defined.

In summary, this new edition has increased its worth and scope as a reference and teaching aid. The greater concern for the patient as an individual, combined with the technical aspects of patient care, enhances its value.

Jamieson's Illustrations of Regional Anatomy (7 vols.), 9ed., revised by Robert Walmsley and T.R. Murphy. London, England, Churchill Livingstone, 1971, 1972. Canadian Agent: Longmans, Don Mills, Ont.

Reviewed by Judith Hindle, Coordinator of Biophysical Science, Vanier School of Nursing, Ottawa, Ontario.

This is a series of seven wire-bound, soft cover books each averaging about 54 pages, and each devoted to drawings of a specific region of the anatomy. They are as follows: nervous system, head and neck, abdomen, pelvis, thorax, upper limb and lower limb. Originally designed to provide medical students with a "simple atlas" by which they could study regional anatomy, the books continue to espouse and serve this purpose. Since these books are focused completely on anatomy, questions relating to function would require reference to a physiology text.

#### books

A list of plates and abbreviations and an index are contained at the beginning and end of the book respectively. In between are pages of brilliantly colored, clearly delineated and concisely labeled drawings of almost every body segment a student might be required to learn. In each instance, anatomical components of a region and the relationship between these components are clearly illustrated from several views — anterior, posterior, medial, lateral, superior, inferior, and so forth. Bone placement, muscle supply, and nerve innervation are also clearly shown.

Depictions of blood vessels, nerves, and organ placement, in the books on the thorax, abdomen, and pelvis, are particularly useful when one is trying to ascertain the effects of disease processes and surgery in these regions. The section on the head and neck is also excellent for its visualizations of areas such as the interior of the larynx, the root of the neck, and the upper surface

of the base of the skull.

There are several advantages to be gained from having this set of books available to nursing practitioners, teachers, and students. Because they are small, lightweight, focused on specific segments, and illustrated clearly enough to be used with an overhead projector, the books lend themselves for use in a variety of teaching situations. They contain anatomical illustrations that nursing teachers are often hard pressed to find in standard anatomy and physiology texts but that are often needed to clarify a point or to demonstrate a relationship.

Finally, they enable the reader to visualize a part separately, and in juxtaposition with other parts, from more views than are available in other texts—an important feature when the physiological implications of disease processes are being considered. Altogether these books would be a valuable addition to nursing and hospital

libraries.

1973 National Reports of ICN Member Associations by International Council of Nurses. 150 pages. Publication no. 7, International Council of Nurses, Geneva, Switzerland, 1973.

The reports of the ICN member associations appear in 1973 in a new form: a loose-leaf binder with each country on a separate page. Reports of new ICN members, as well as reports of those

few member associations received too late for inclusion in this printing, may be added in alphabetical order.

In addition to the individual reports from each country, the 1973 volume includes a number of tables and charts containing information collected and compiled for the first time: the number of male nurses in each association, the number and type of salaried head-quarters staff, the relative importance of various sources of association income, and the various levels of responsibility for 25 different functions of nurses' associations.

This volume is a valuable addition to any nursing reference library.

Introduction to Patient Care: A Comprehensive Approach to Nursing, 2ed., by Beverly Witter Du Gas. 487 pages. Toronto, Saunders, 1972. Reviewed by D. Wood, Teacher, School of Nursing, Grace General Hospital, Winnipeg, Manitoba.

In this new edition, the objective of the first section is to help the student develop judgment in assessing patient needs and in selecting, carrying out, and evaluating the effectiveness of her actions. The problem-solving process is used and referred to by the author as the "nursing process." The nursing history is included as part of problem solving. Observational skills and charting conclude this section.

The second section deals with meeting the basic needs of people with health problems. A new chapter has been added here, entitled "The Needs of the Patient for the Relief of Anxiety." It discusses the nurse's approach to an anxious patient, the signs and symptoms, and physiological and psychological manifestations of anxiety.

Included in this section are the spiritual needs of the patient with some reference made to the role of the hospital chaplain. The remaining portion of this section deals with body mechanics, positioning and comfort devices, hygienic needs, nutrition, and safety needs. These are approached in much the same way as most nursing texts.

The third section on the legal implications of nursing practice includes such topics as the expanding role of the nurse, the nurse's responsibility in regard to wills, and Good Samaritan laws. There is a short reference to Canadian narcotics laws. This section of the text also includes the nurse's role in diagnostic and therapeutic care.

The fourth section discusses common health problems, such as fever, pain, dyspnea, and so on. Discussion of each problem includes scientific principles, signs and symptoms, nurse's assessment

of the patient's need, and the nursing measures related to the need. At the end of each discussion there are questions to help the student assess the nursing need and evaluate the effectiveness of nursing action.

The author indicates in the preface that the text is intended as an introductory text for nursing students. I believe it would satisfy this purpose.

The Process of Planning Nursing Care: A Theoretical Model, by Fay Louise Bower. 139 pages. St. Louis, Mosby, 1972.

Reviewed by Kathleen M. Rowat, Assistant Professor of Nursing, School of Nursing, McGill University, Montreal, Quebec.

In the preface, the author identifies the two main purposes of this book: "to help nurses develop increased skill in decision making as the process of planning care," and "to present a theoretical framework for nurses that will enable them to plan holistic care, to plan care that meets the needs of the person as he responds holistically to his environment."

The book initially presents an overview of the process of planning nursing care. This is examined within the framework of a "stress-response model" that incorporates such concepts as existentialism, humanism, and holism.

The major portion of the book deals with the elements of the planning process — identification of the nursing problem, selection of appropriate nursing action, and evaluation of the outcomes. The final chapter illustrates how these ideas can be used in the development of nursing care plans.

This format provides an approach in depth to these various stages of the planning process; the inclusion of clinical examples adds strength to the discussion. Throughout the book, the author illustrates how this process is applicable in any setting, whether it is an acute care center or the community at large.

The author emphasizes the importance of viewing the "client" as the main source of data collection and stresses the necessity of stating the problem and proposed solutions in

behavioral terms.

Although the ideas presented in this little book may not be new, the inclusion of notions such as probability theory to examine possible consequences of alternate nursing approaches may provide the reader with a somewhat different outlook on this subject. At the conclusion of each chapter, the author includes a list of suggested readings for those wanting to pursue the ideas further.

#### books

For the student or graduate in nursing who wishes to gain an understanding of the nursing process, this book may well serve the purpose.

Patient-Nurse Interaction by Annie T. Altschul. 235 pages. London, England, Churchill, Livingstone, 1972. Canadian Agent: Longmans, Don Mills, Ontario.

Reviewed by Norma Karlinsky, Psychiatric Nursing Instructor, School of Nursing, University of Calgary, Calgary, Alberta.

This book, which is an outgrowth of the author's research for her MSc thesis, attempts to pinpoint what makes patient-nurse interaction "therapeutic.

She has exhaustively searched the literature and, throughout the book, summarizes the findings and method-

ology of other researchers.

The author has used many variables to conduct her research, such as: number of interactions, length of hospital stay, age of the patient, diagnosis, and social class. She has also interviewed both patients and nurses regarding the content of their interactions.

Possibly because the research is based on observations begun in 1961, and uses only four psychiatric wards (Royal Edinburgh Hospital, London), she does not arrive at any new or different conclusions. She does make some recommendations regarding the education of nursing students in Britain. She also suggests that communication patterns among ward staffs could be improved to include more discussion of approaches, philosophies of treatment, and successes and failures in interactions.

It seems to the reviewer that there are considerable differences in the nursing situations described and those personally observed in Canadian hospitals. The use of the therapeutic community approach, as well as the implementation of the nursing team, in Canadian psychiatric hospitals seems to provide different and/or more successful modes for "therapeutic interaction."

The book would be somewhat complex and too research-oriented for student use. Nursing reference libraries, however, could find it useful as a source of research tools and methodology and as a summary of past literature on the nurse-patient relation-

ship. **JULY 1973**  Pharmacology in Nursing, 12ed., by Betty S. Bergersen. 682 pages. Saint Louis, Mosby, 1973.

Reviewed by Aleyamma Varghese, Teacher, Hamilton Civic Hospitals School of Nursing, Hamilton, Ont.

The scientific knowledge underlying pharmacology does not make a nurse a "mini" doctor; instead, if used with wisdom, it would only make her actions more meaningful to herself as a safe practitioner.

This twelfth edition contains a substantial amount of current material. Each chapter begins with a succinct list

of contents to be discussed.

Adequate knowledge of weights and measures still remains a stumbling block in the calculations of fractional dosages of drugs. The chapter on weights and measures is clearly presented, equating the units of measurements used in various systems with specific exercises for application.

The drugs are mentioned with their generic and trade names. Modes of action, dosages, side effects, and toxic effects are well defined. The text deals with brief, simple, physiological principles of drugs rather than their broad, chemical structure. This is comprehended well by the students.

Extensive references for every chap-

RN.'s

#### SPEEDY PLACEMENT IN SUNNY CALIFORNIA

Immediate staff positions to \$904/mo. (\$10,848.a) plus major benefits. Other openings/salary commensurate to education and experience.

U.S. entry & work permit (yearly term) obtainable within 30 days. You do not have to appear at the U.S. Consulate for your visa. Housing accommodations & relocation assistance. Airfare advanced.

Over 50 general hospitals, variety of sizes, specialties & locations.

FREE: We do all paper work,

NO PLACEMENT FEE.

PROFESSIONAL NURSE RECRUITERS (Authorized Rep. of Hospitals) 1316 Wilshire Blvd., Suite 12 Los Angeles, California 90017

Tél.: (213) 483-8388 or 483-8389

Without obligation, please send me more information and an application form.

Name		
Addre	ss:	
Tel.:	( )	
Licens	ses:	(
		*************************
		Prov

ter allow for more information if desired. Pertinent related questions with short answers and multiple choice are interjected to guide the reader in the recollection of material freshly gained from the text. The addition of a chapter on drug abuse is a stimulus to serious thinking in this present era of self-medication.

Though nursing implications for some of the drugs are listed, specific points for patient teaching should be included for all drugs, since this knowledge is poorly demonstrated by personnel in clinical practice.

The text is organized systematically, clearly, and concisely. It is recommended as a reference for all, and a text for

basic nursing students.

The Pharmacologic Basis of Patient Care, 2ed., by Mary K. Asperheim and Laurel A. Eisenhauer. 526 pages. Toronto, Saunders, 1973. Reviewed by Irma K. Riley, Associate Professor of Nursing, School of Nursing, McGill University, Montreal, Quebec.

A keen interest in pharmacology as it is related to nursing led to my review of this book. One's first reaction is why Saunders would publish this replica of other companies' offerings in this field, instead of the one they did publish that was different.

The authors state the nurse is faced with an environment that her education has helped her meet. This book does not reflect this statement. It is rigidly structured and tries to cover every possible event. It seems to me that a conscientious student and the competent practitioner would ask for a book that presents material clearly and leads to pertinent references.

For example, acetylsalicylic acid is a much-used drug for both adults and children. The authors mention candytype aspirin, but there is no direction as to what the range and frequency of dose for a child might be. Questions relating to the patient receiving an analgesic are in six sections. I wonder if they would lead to asking if aspirin is a safe as well as a dangerous drug? The bibliography does include an article on this topic.

A book on this topic should help to expand one's clinical experience, not to discourage, by its format, one's use of

a reference.

One wonders what level of student or practitioner this book is written for. It is sad that this second edition to a book that was outmoded in its approach in 1968 has been published in 1973. Will nurses ever tell authors that books like this are not helpful when they are students, and less so when they are practitioners?

Home Care and Extended Care in a Comprehensive Prepayment Plan by Arnold V. Hurtado, Merwyn R. Greenlick, and Ernest W. Saward. 127 pages. Chicago, Hospital Research and Educational Trust, 1972.

Some major controversies about the Hastings Report are concerned with whether the report fairly represented the history and potential of health care facilities linked with prepaid insurance. Although this paperback reports on a study carried out in the United States, it has much to say that could be applicable in Canada.

This is the report of a demonstration project carried out in Portland, Oregon, between July 1967 and January 1969. Patients for the demonstration were members of the Kaiser Health Plan.

Primary objectives of the project were to ascertain the feasibility of integrating home care and extended care facility (ECF) services into an ongoing, comprehensive, prepaid group practice plan; to train new personnel to provide professional services; to analyze the use of home care and ECF services in a comprehensive, integrated medical program; to evaluate the impact of home care and ECF services in hospital use; and to determine the cost of providing such services.

Nurses were involved in many aspects of administering and providing the home care and ECF services.

This report will interest nurses working in home care or extended care facilities and graduate students wishing to learn about research methods. It is of general interest for all nurses who want to understand more fully the possibilities of other methods of organizing health care.

#### accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, except reference items, may be borrowed by CNA members, schools of nursing and other institutions. Reference (R) items (archive books and directories, almanacs and similar basic books) do not go out on loan. Theses (also R) are on Reserve and may go out on Interlibrary loan only.

Request for loans should be made on the "Request Form for Accession List" and should be addressed to: The Library Canadian Nurses' Association, 50 The Driveway, Ottawa, Ont. K2P 1E2. No more than *three* titles should be requested at any one time.

#### BOOKS AND DOCUMENTS

1. Annotated guide to health instruction materials in Canada 3ed. Ottawa, Canadian Health Education Specialists Society, 1972. 90p.

2. Basic documents. 23ed. Geneva, World Health Organization, 1972. 164p.

3. Blakiston's Gould Medical dictionary. 3ed. Toronto, McGraw-Hill, 1972. 1828p.R

4. Bourinot's rules of order, by John George Bourinot. 2ed: Rev. by J. Gordon Dubeoy. Toronto, McClelland and Stewart, c1963; reprinted 1972. 116p.

5. Corpus directory and almanae of Canada, 1973. Toronto, Corpus Publishers Services Ltd., 1973. 1 vol. R

6. Current therapy, 1973. Philadelphia, Saunders, 1973. 911p.

7. ESP in life and lab; tracing hidden channels, by Louisa E. Rhine. New York, Macmillan, 1967. 275p.

8. The economics of medical care, Edited by M.M. Hauser. London, Allen & Unwin, 1972. 334p. (University of York. Studies in economics no.7)

9. Enrollment in Ontario Colleges of Applied Arts and Technology: projections to 1981/82, by Cicely Watson et al. Toronto, Ontario Institute for Studies in Education, (Enrollment projection series no.7)

10. Final report of International Workshop on Communications in Family Planning Programs, Teheran, 1970. Edited by Robert R. Blake. Chapel Hill, N.C., Carolina Population Center, University of North Carolina, 1971. 178p.

11. Gynaecology for students of nursing, by John Cairney and J. Cairney, 5ed. Edited and rev. by Trevor C. Svensen. Christchurch, New Zealand, Preyer, 1972. 252p.

12. Introduction to asepsis; a programed unit in fundamentals of nursing, by Marie M. Seedor. 2ed. New York, published for the Dept. of Nursing Education by Teachers College Press, Columbia University, 1972. 280p. (Nursing education monograph no.3)

13. Mayes' midwifery; a textbook for midwives, by Rosemary E. Bailey. 8ed. London, Baillière Tindall, 1972. 530p.

14. The medical uses of ionizing radiation and radioisotopes; report of a Joint IAEA| WHO Expert Committee. Geneva, World Health Organization, 1972, 56p. (Its Technical report series no. 492)

15. Nutrition and diet therapy, by Sue Rodwell Williams. 2ed. St. Louis, Mosby, 1973. 693p.

16. Ontario university and college enrollment projections to 1981/82, by Cicely Watson and Saeed Quazi. Toronto, Ontario Institute for Studies in Education, 1969. 57p. (Enrollment projection series no.4)

17. Principles of nursing, by Nancy Roper. 2ed. Edinburgh, Churchill Livingstone, 1973. 313p.

18. Proceedings of annual conference, 1972. Ottawa, Canadian Library Association, 1973. 101p.

19. Psycho-cybernetics; a new way to get more living out of life, by Maxwell Maltz. Hollywood, Calif., Wilshire Book Co., 1969. 256p.

20. Psychological medicine for students, by John Pollitt. London, Churchill Livingstone, 1973. 294p.

21. Psychosocial nursing. Studies from the Cassel hospital. Edited by Elizabeth Barnes. London, Associated Book Publishers, 1968. 316p.

22. Quest for the optimum: research policy in the universities of Canada. Report by Louis-Philippe Bonneau and J.A. Corry. Ottawa, Association of Universities and Colleges of Canada, 1972. 2 vols.

23. Review of nutrition and diet therapy, by Sue Rodwell Williams. St. Louis, Mosby, 1973. 293p. (Mosby's comprehensive series)

24. Taber's cyclopedic medical dictionary. 12ed. rev. and edited by Clayton L. Thomas. Philadelphia, Davis, 1973. 1 vol. **R** 

25. Teaching guide to accompany the second edition of Nutrition and Diet Therapy, by Sue Rodwell Williams. St. Louis, Mosby, 1973. 85p.

26. Twenty-fourth report of WHO Expert Committee on Biological Standardization. Geneva, World Health Organization, 1972. 61p. (Its Technical report series no. 486)

#### PAMPHLETS

27. Applying models to the family planning programs of developing countries, by Curtis P. McLaughlin. Chapel Hill, N.C., Carolina Population Center, University of North Carolina, 1972. 33p. (Carolina Population Center. Program design paper 2)

28. Brief on employer-employee relations in the government of British Columbia. Vancouver, B.C. Registered Nurses' Association of British Columbia, 1972. 12p.

29. A brief to the Minister of National Health and Welfare and the Ministers of Health of the Provinces on the delivery of health care and the cost of health services as a result of the Health action '72 conference Prepared by the liaison committee of the CMA/CNA/CHA. Ottawa, Canadian Nurses' Association, 1972. 17p.

30. Catalogue of films and filmstrips. Toronto, Canadian Cancer Society, Ontario Division, 1972. 19p.

31. Implications of individual and small group learning systems in medical education; report of a WHO Study Group. Geneva. World Health Organization, 1972. 29p. (Its Technical report series no. 489)

32. Prototype agreement concerning the use of clinical facilities for student nurse experiences. Toronto, Ontario Hospital Association, 1973. 8p.

33. Public Affairs Committee. Pamphlets. no.486 What do we know about allergies? by Michael H.K. Irwin. New York, 1972. 28p.

34.—.no.487 A new look at cooperatives, by Philip J. Dodge, New York, 1972, 28p, 35.—.no.488 Depression: causes and treat-

#### accession list

ment, by Theodore Irwin. New York, 1973.

36 .- . no.489 the Bill of Rights today, by Thomas I. Emerson. New York, 1973. 28p. 37. Report of the Task Force to study the implications of the recommendations presented in an abstract for action. New York. National League for Nursing, 1972, 8p.

38. Standards for personnel training in mental retardation and related developmental handicaps. Downsview, Ont., National Institute on Mental Retardation, 1973. 14p.

#### GOVERNMENT DOCUMENTS

Canada

39. Conference on the human environment. A report on Canada's preparation for and participation in the United Nations Conference on the Human Environment, Stockholm, Sweden, June 1972. Ottawa, Information Canada, 1972, 71p.

40. Dept. of National Health and Welfare. Nursing resources in Canada. An analysis of the current situation, projections regarding supply and requirement; interim objectives, by Beverly Witter Du Gas. Rev. Ottawa, 1973. 5p.

41. Economic Council of Canada. Annual review, 1972. Ottawa, Information Canada, 117p.

42. Labour Canada. Labour organizations in Canada, 1971. Ottawa, Information Canada, 1972. 156p.

43. - . Wage rates, salaries and hours of labour, 1971. Ottawa, Information Canada, 1972. 536p.

44. National Library of Canada. Research collections in Canadian libraries. Ottawa. 1972. 2 vols. (v.2, universities - Atlantic provinces.-v.3, universities - British Colum-

45. Statistics Canada. Annual salaries of public health nurses, 1970. Ottawa, Information Canada, 1973, 45p.

46 .- . Canadian community colleges and related institutions, 1970/71. Ottawa, Information Canada, 1972, 97p.

47.—. Health manpower registered nurses, 1971. Ottawa, Information Canada, 1973.

48 .- .. Hospital statistics, 1970. Ottawa, Information Canada, 1973. 7 vols.

49 .- List of Canadian hospitals and related institutions and facilities, 1973. Ottawa, Information Canada, 80p.

50 .- Vital statistics; preliminary annual report, 1971. Ottawa, Information Canada, 1973. 63p.

51. Travail Canada. Grèves et lock-out au Canada, 1970. Ottawa, Information Canada, 1972.80p.

Ontario

52. Ministry of Government Services. The learning society; report of the Commission on Post-Secondary Education in Ontario.

Toronto, 1972, 266p.

United States

53. National Center for Health Statistics. Nursing homes: their admission policies, admissions, and discharges: United States-April-September 1968. Washington, Public Health Service, 1972. (Vital and health statistics, series 12, no.16)

54 .-. Services and activities offered to nursing home residents, United States - 1968, Washington, Public Health Service, 1972. (Vital and health statistics series 12, no.17) 55. National Library of Medicine. Bibliography of the history of medicine 1964-1969. Bethesda, Maryland, 1972, 1475p, R

STUDIES DEPOSITED IN CNA REPOSITORY COLLECTION

56. Alienation: alone, apart, awake, astarte, by Alice E. Caplin. Detroit, Mich., 1971. 33p. (Thesis (M.Sc.N.) - Wayne State) R

57. The comprehensive health care project: a preliminary study by Virginia K. Elahi and M. Gail MacDougall, Halifax, Dalhousie University, Dept. of Preventive Medicine. Faculty of Medicine, 1972. 182p. R

58. Falls in hospitals: a research study using four hospitals during the year 1971, by Annie Elizabeth Clark. Calgary, Alberta, 1972. 18p. R

59. An operant conditioning program in selfmotivation and self-control with subjects acting as change agents, by Therese F. Carignan. Seattle, 1972. 77p. (Thesis (M.A.) -Washington) R

### Request Form for "Accession List"

#### CANADIAN NURSES' ASSOCIATION LIBRARY

Send this coupon or facsimile to: LIBRARIAN, Canadian Nurses' Association, 50 The Driveway, Ottawa K2P 1E2, Ontario.

		ng publications, listed in the issue of The Canadian Nurse
		waiting list to receive them when
Item No.	Author	Short title (for identification)

Request for loans will be filled in order of receipt. Reference and restricted material must be used in the CNA library. Borrower ..... Registration No.

Position ..... Address .....

Date of request .....

## MANAGER

We require a Manager with proven managerial skills to be responsible for a large Central Supply Service.

The person we seek should have experience in a teaching hospital and several years experience in a managerial position, preferably in a Central Supply Service.

Salary commensurate with experience and qualifica-

Apply

PERSONNEL OFFICE TORONTO GENERAL HOSPITAL 101 College Street. Toronto, Ontario. M5G 1L7

#### classified advertisements

ALBERTA

ALBERTA

BRITISH COLUMBIA

WANTED: ASSISTANT EXECUTIVE DIRECTOR — NURSING 400-bed active Convalescent-Rehabilitation Hospital including 100-beds for School Hospital activities. Large Departments of Nursing, Physiotherapy, Occupational Therapy, Psychology, Speech/Audiology, Social Service, and Recreational Therapy, A busy Out-Patient Department provides for Assessment Clinics, Meningomyelocele, Convulsive Disorders, etc., mainly involving children. This is the top position in the Nursing establishment A Master's Degree is preferred and salary is competitive. Write to: W.G. McPhail, M.D., Executive Director, Glenrose Provincial General Hospital, 10230—111 Avenue, Edmonton, Alberta T5G 0B7.

EMPLOYMENT OPPORTUNITY — Athabasca Health Unit No. 18 requires a Senior Nurse immediately for the Athabasca Unit Office. Diploma in Public Health preferred but not essential. Salary in accordance with the L.H.S. 12 Salary Schedula plus 8%. Salary range of Senior Nurse (without DPHN) 7200 — 8280 plus 8%. — Senior Nurse (with DPHN) 7200 — 8280 plus 8%. — Senior Nurse with (BSc Public Health) 8280 — 9528 plus 8%. Salary range varies according to qualifications and experience. Send application to: Mr. V. Markowski, Secretary-Treasurer, Athabasca Health Unit No. 18, P.O. Box 1140, Athabasca, Alberta.

REGISTERED NURSES required for a 30-bed Genral Hospital, salary and Personnel Policies as per AARN. Location of hospital, 30 miles east of Lecombe, Highway No. 12. For more information write or shone 882-3434. Director of Nursing, Our Lady of the Rosary Hospital, Castor, Alberta.

#### ADVERTISING RATES

FOR ALL
CLASSIFIED ADVERTISING

\$15.00 for 6 lines or less \$2.50 for each additional line

Rates for display advertisements on request

Closing date for copy and cancellation is 6 weeks prior to 1st day of publication month.

The Canadian Nurses' Association does not review the personnel policies of the hospitals and agencies advertising in the Journal. For authentic information, prospective applicants should apply to the Registered Nurses' Association of the Province in which they are interested in working.

Address correspondence to:

Canadian Nurse



50 THE DRIVEWAY OTTAWA, ONTARIO K2P 1E2 MISERICORDIA HOSPITAL, EDMONTON, ALBERTA. An extensive range of positions are available for REGISTERED NURSES, in such areas as: I.C.U., SURGERY, MEDICINE, PAEDIATRICS, and OBSTETRICS. We have 555-beds in our modern, airconditioned, active treatment and teaching Hospital. If you are interested in joining us and expanding your knowledge and experience, please apply to: Personnel Department, 16940 - 87th Avenue, Edmonton, Alberta.

REGISTERED NURSES. The Red Deer General Hospital requires nurses with an interest in a variety of Medical, Surgical, Obstetrical and Paediatric positions. We have several immediate openings in our progressive 240-bed hospital. Please apply to: Personnel Department, Red Deer General Hospital, Red Deer, Alberta or phone 346-3321 for further information.

#### BRITISH COLUMBIA

REGISTERED NURSES — SUPERVISOR position available in 123-bed modern General Experience and formal preparation required. RNABC contract in effect. Apply: Director of Nursing, Matsqui-Sumas-Abbotsford General Hospital, Abbotsford, British Columbia.

NURSING CO-ORDINATOR (Supervisor) for Obstetrical and Gynecological Services — HEAD NURSE for Obstetrical/Gynecological ward. Progressive department with family-centred approach to patient care. Apply to: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

SUPERVISOR of O.R., P.A.R. & C.S.R. Depts., required for 86 acute-care bed pediatric hospital. Experience essential. Post-graduate training desirable. Apply: Director of Nursing, Children's Hospital, 250 West 59th Avenue, Vancouver 15, British Columbia.

SUPERVISOR — Evening and night rotation — required for 86-bed acute-care pediatric hospital. Applicants with background in pediatrics and administration preferred. Apply: Director of Nursing, Children's Hospital, 250 West 59th Avenue, Vancouver 15, British Columbia.

INTENSIVE CARE UNIT TRAINED NURSES required for 120-bed General Hospital. Salary as per RNABC contract. Nurses' Residence accommodation available. Apply to: Director of Nursing, Powell River, General Hospital, 5871 Arbutus Street, Powell River, British Columbia.

GRADUATE NURSES for 21-bed hospital preferably with obstetrical experience. Salary in accordance with RNABC. Nurses residence. Apply to: Matron, Tofino General Hospital, Tofino, Vancouver Island, British Columbia.

OPERATING ROOM NURSE wanted for active modern acute hospital. Four Certified Surgenns on attending staff. Experience or training desirable. Must be eligible for B.C. Registration. Nurses residence available. Salary \$687 per month starting. Apply to: Director of Nursing, Mills Memorial Hospital, 2711 Tetrault St., Terrace, British Columbia.

GENERAL DUTY AND OPERATING ROOM NURSES for modern 450-bed hospital with School of Nursing. RNABC policies in effect. Credit for past experience and postgraduate training. B.C. Registration required. For particulars write to: Acting Director of Nursing Service, Victoria General Hospital, Victoria, British Columbia.

Positions evailable for REGISTERED NURSES for general duty in the Operating Room, Surgical, Intensive Care and Extended Care areas. MALE REGISTERED NURSES are required for the 20-bed Psychiatric ward. Salaries and Personnel Policies in accordance with the RNABC agreement. Apply to the: Director of Nursing, Chilliwack General Hospital, Chilliwack, British Columbia.

REGISTERED NURSES AND LICENSED PRACTICAL NURSES WANTED FOR FULLY ACCREDITED HOSPITAL EXPANDING TO 190 BEDS IN THE FALL OF 1973. ADMINISTRATIVE. SUPPERVISORY AND GENERAL DUTY CATEGORIES IN MEDICAL-SURGICAL, PSYCHIATRIC AND ICU-CCU AREAS. MUST BE ELIGIBLE FOR B.C. REGISTRATION. BASIC SALARY \$672.00. APPLY: DIRECTOR OF NURSING, ST. JOSEPH'S GENERAL HOSPITAL, COMOX, BRITISH COLUMBIA.

EXPERIENCED NURSES required in 409-bed acute Hospital with School of Nursing. Vacancies in medical, surgical, obsletric, operating room, pedialric and Intensive Care areas. Basic salary \$672.—\$842. B.C. Registration required. Apply: Director of Nursing. Royal Columbian Hospital, New Westminster, British Columbia.

EXPERIENCED GENERAL DUTY NURSES — required for small up-coast hospital. Salaries start at \$672.00. Residence accommodation at \$25.00 per month, 20 days annual vacation. Transportation paid from Vancouver, B.C. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia.

GENERAL DUTY NURSES for modern 41-bed hospital, located on the Alaska Highway. Salary and personnel policies in accordance with RNABC, Accommodation available in residence. Apply: Director of Nursing, Fort Nelson General Hospital, Fort Nelson, British Columbia.

WANTED: GENERAL DUTY NURSES for modern 70-bed hospital, (48 acute beds — 22 Extended Care) located on the Sunshine Cdast, 2 hrs. from Vancouver. Salaries and Personnel Policies in accordance with RNABC Agreement. Accommodation available (female nurses) in residence. Apply: The Director of Nursing, St. Mary's Hospital, P.O. Box 678, Sechelt, British Columbia.

GENERAL DUTY NURSE wanted for 87-bed modern hospital, Nurses Residence. Salary \$646.00 per month for BC Registered. Apply: Director of Nursing, Mills Memorial Hospital, Terrace, British Columbia.

#### MANITORA

HEAD NURSES and REGISTERED NURSES for general duly required. Please apply to: Personnel Director, Morris Hospital District No. 25 & Red River Valley Lodge, Inc., Box 519, Morris, Manitoba, ROG 1KO.

ADVENTUROUS NURSES: A registered non profit organization seeks Canadians to share in 2 yr, academic excursion to Latin America. Tesk: to promote greater awareness of Canada on cultural & educational lines; to lecture on various subjects from arts to applied & pure sciences; to drive 55,000 miles along Pan American Hwy., throughout 17 countries. Requirements; should be self solvent; have good knowledge of Canadiana and be versed in contemporary Latin American developments; must speak French, Spanish, or Portuguese although other ethnic tongues ie. German, Austrian, Italian an asset. Couples welcome to apply providing mate can contribute. Preference given to University graduates. Reply with short resume & telephone number to: Canadians Introducing Canada Inc., P.O. Box 601, Winnipeg, Manitoba R3C 2K3.

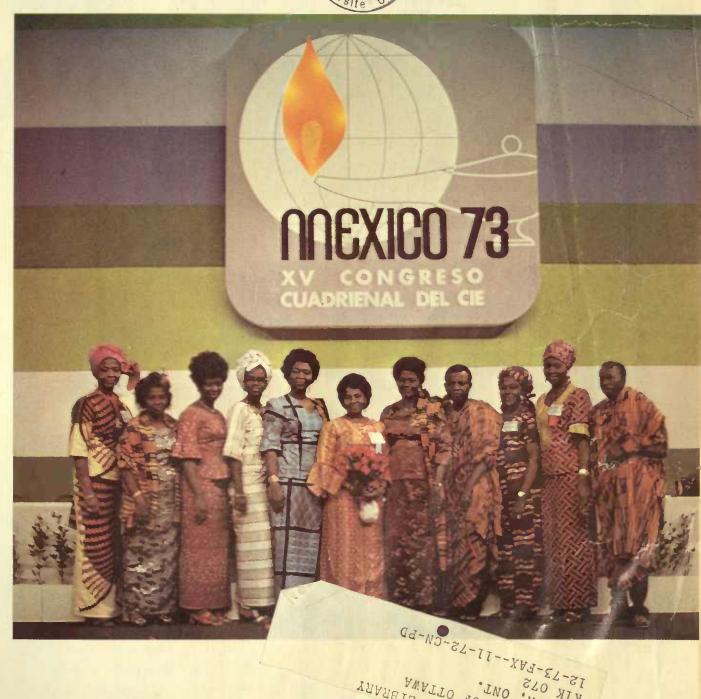
#### NEWFOUNDLAND

GENERAL DUTY NURSES required for 37-bed active treatment hospital in South-Wesl Newfoundland. Salary and policies in accordance with Provincial contracts. Accommodations available in residence. The hospital serves 18,000 people and is located in a community of 6,000. Enquiries should be directed to: Director of Nursing, Channel Hospital, Channel-Port aux Basques, Newfoundland.

# The Canadian Nurse

August 1973 🔆

DO NOT YERE OUT OF LILERARY



SCHOOL OF NURSING LIBRARY OF OTTAWA





5 9 10 2 6 3 7 11 8 12 Serving the health professions in Canada since 1897 J. B. Lippincott Co. of Canada Ltd. 75 Horner Ave. Toronto, Ontario M8Z 4X7 Representing in Canada: Position Postal Code ..... Little, Brown and Company Blackwell Scientific Publications Ltd. Payment enclosed (send postpaid) Use my Chargex number Springer Publishing Company, Inc. Books may be returned within 15 days Charge and bill me



For a complimentary pair of white shoelaces, folder showing all the smart Clinic styles, and list of stores selling them, write: THE CLINIC SHOEMAKERS • Dept. CN-8, 7912 Bonhomme Ave. • St. Louis, Mo. 63105

# The Canadian Nurse



A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 69, Number 8

August 1973

- 29 Handicapped Children Learn
  Written Communication ..... E. Maser

The views expressed in the editorial and various articles are those of the authors and do not necessarily represent the policies or views of the Canadian Nurses' Association.

4	Letters	41	Dates
7	News	42	Books
38	Names	44	Accession List
40	In a Capsule	56	Index to Advertisers

Executive Director: Helen K. Mussallem • Editor: Virginia A. Lindabury • Assistant Editors: Liv-Ellen Lockeberg, Dorothy S. Starr • Editorial Assistant: Carol A. Dworkin • Production Assistant: Elizabeth A. Stanton • Circulation Manager: Beryl Darling • Advertising Manager: Georgina Clarke • Subscription Rates: Canada: one year, \$6.00; two years, \$11.00. Foreign: one year, \$6.50; two years, \$12.00. Single copies: \$1.00 each. Make cheques or money orders payable to the Canadian Nurses' Association. • Change of Address: Six weeks' notice; the old address as well as the new are necessary, together with registration number in a provincial nurses' association, where applicable. Not responsible for journals lost in mail due to errors in address.

Manuscript Information: "The Canadian Nurse" welcomes unsolicited articles. All manuscripts should be typed, double-spaced, on one side of unruled paper leaving wide margins. Manuscripts are accepted for review for exclusive publication. The editor reserves the right to make the usual editorial changes. Photographs (glossy prints) and graphs and diagrams (drawn in india ink on white paper) are welcomed with such articles. The editor is not committed to publish all articles sent, nor to indicate definite dates of publication.

Postage paid in cash at third class rate MONTREAL, P.O. Permit No. 10,001. 50 The Driveway, Ottawa, Ontario. K2P 1E2

Canadian Nurses' Association 1973.

The recent congress of the International Council of Nurses was delightful in many ways; one panel chairman referred to "the soul of Mexico — music, charm, and gaiety." There was mariachi music, spicy food, and a waiter who wished me "the sleep of the little angels" as I left after the late Mexican dinner hour.

But the business sessions were dismaying: few nurses recognized the needs and desires of nurses from countries struggling to establish health care and to increase professional autonomy.

The words: colleague, collègue, and colega were used frequently during the congress. But, I wondered, who are our colleagues? White, middle-class, North Americans?

The ICN Council of National Representatives is not solely responsible for the lack of internationalism in decisions made at the 15th quadrennial congress. These representatives can take positions only sightly ahead of their constituents.

Reports of ICN officers and committees clearly forecast the result of alternative actions. Nevertheless, national interests won over internationalist choices by a big majority when decisions were voted on decisions to provide ICN with the slenderest of budgets, while opening the opportunity of ICN membership to nursing personnel other than registered nurses and to nursing sections of multidisciplinary groups, such as unions.

To recruit and provide services to a disparate group of members will require travel for staff and officers, correspondence, representation with other international groups: in other words, money.

"Nurses in our country don't feel they need ICN," someone from a country in the European Common Market told me. In Mexico City, six national associations — four from Africa, one each from the Caribbean area and from South America — were admitted to ICN membership. The nurses of these countries believe they need ICN. And a strong ICN needs funds for staff and services.

The ICN budget will come up again at the CNR meeting in Singapore in 1975. Canada, as the second-largest member association of ICN, can have an impact on that discussion. Our concern for nurses and nursing, especially in countries outside North America and northern Europe, should lead us to support a fee increase to provide ICN with the funds to do what can be done only at the international level. — D.S.S.

## letters

Letters to the editor are welcome.

Only signed letters, which include the writer's complete address, will be considered for publication.

Name will be withheld at the writer's request.

Comments on May article

In the May 1973 issue, Dirksen and Meilicke's article "Surgical Separation of Conjoined Twins" provided a detailed description of nursing objectives and care for these twins.

Particularly impressive was the totality of the care, which included measures such as promoting social and sensory development and normal parent-sibling relationships. Including the family in the care was a fundamental issue.

There was, however, one aspect of the article that was a disappointment. Although there was a full account of the preparation and equipment for surgery, there was no information as to how this surgical separation was actually carried out. Surely there is a place in nursing journals for this information. — Catherine Harrop, student, McMaster University School of Nursing, Hamilton, Ontario.

Author replies

Before writing the article, Dorothy Mielicke and I discussed whether the surgical procedure, surgical statistics on successes, and etiology and classification of conjoined twins should be included in the article. As we thought they were not directly related to nursing nor to nurses' responsibilities, they were not included.

As the surgical procedure has been well documented in medical journals, we believed that persons interested in these details would consult our references. — W.S. Dirksen, assistant director, special services, University of Alberta Hospital, Edmonton, Alberta.

Insulted by article

It was with delight that I saw the picture of coinjoined twins on the May cover of *The Canadian Nurse*. I only wish I had shared the same delight with the article! In a decade in which nurses are striving for an expanded role and recognition of their potential in total health care, I found this article an insult to my intelligence.

How can we hope to become nurse practitioners when our national (and compulsory) magazine prints, and our leaders produce, kindergarten material? If this is the level of understanding, I suggest we all go back for retraining or possibly recycling!

Do we not have the common sense to know what isolation technique is, without being told to wash our hands? Do we have to be retold five times in a five-page article that physical contact leads to emotional security? Is it important or even interesting that Edmonton nurses begin work at 0700 hours? Are hospitalized infants not usually bathed? I could continue.

Please, sister nurses, let's graduate from diapers into training pants. — Elisabeth Vincent, Regina, Saskatche-

June issue unique

The June issue of *The Canadian Nurse* was indeed unique, with the inclusion of the article by K.G. DeMarsh, "Red Cross Outpost Nursing in New Brunswick."

Ms. DeMarsh vividly shows that "nurses are prepared to meet the continually changing and emerging demands for their services." In 1946, the demands were met by a registered nurse on Miscou Island. Today, RNs are prepared to meet the demands of the twentieth century in a similar way.

Do nurses need a course in the role of the nurse practitioner or nursing in a primary health care unit? Perhaps they do in today's society. But Ms. De-Marsh's article makes us stop and wonder what "primary health care" really means. — Thelma 1. Potter, Assistant Professor, The University of Western Ontario, Faculty of Nursing, London, Ontario.

#### Kudos

The following letter was received by Dr. Helen K. Mussallem, CNA executive director. We believe it is of interest to our readers — Editor.

I am writing to express my thanks to your association and to Margaret Parkin, CNA's librarian, for your excellent cooperation with our Center.

We have just arranged to borrow masters' theses and reports from your collection for abstracting for our journal, Abstracts of Hospital Management Studies.

You should be very proud of your collection of research material on nursing and the publication of the issues of "Addendum." I am sorry to say we

have nothing as good in the United States.

Since our journal is read in 35 or 40 countries outside of Canada and the USA, your collection will be having quite an international impact through the description of this material in Abstracts of Hospital Management Studies.

Please feel free to call on our Center for anything you think we might be able to do for your association. — Lewis E. Weeks, Ph.D., Editor, Abstracts of Hospital Management Studies, The Cooperative Information Center for Hospital Management Studies, The University of Michigan, Ann Arbor, Michigan, U.S.A.

Intrigued with June cover

As a proprietor of a general store, I was intrigued with the cover of your June issue.

Would it be possible to obtain the drawing from the artist? I wish to make a poster blowup of the picture, which will hang near the potbellied stove in my store. — D. Butson, Northbrook, Ontario.

#### TM relieves stress

I recently discovered an excellent method for relaxation, which I would like to share.

Anyone who suffers from headaches, tension, or insomnia should try TM — Transcendental Meditation. I discovered it almost a year and a half ago and find it is most satisfying for relieving stress symptoms.

TM is a technique taught by the followers of the Maharishi Mahesh Yogi. That may seem far out to some, as it did to me initially. However, when a friend took me to a couple of lectures, I was pleasantly surprised.

By this simple technique, the individual can achieve a profound state of relaxation and rest. The technique alleviates the built-up stress and tension in the body; by so doing, it frees the stress built up in the person's mind. By relieving this physical and emotional stress, the individual can enjoy other aspects of himself and his environment that are otherwise hidden. With these other aspects unveiled, the individual can develop himself more fully.

This technique is simple — anyone can learn it. It requires no change in

**AUGUST 1973** 

life-style or religion. If anything, it enhances one's beliefs, makes life more enjoyable, and makes social interaction

more fulfilling.

In a stress-ridden world, a technique for achieving rest and alleviating tension is most beneficial and necessary. There are many centers in Canada for learning TM. Everyone can take in a lecture and find out for himself. — Tamara Zujewskyj, Edmonton, Alberta.

OR nurse is puzzled

l am a Roman Catholic nurse, or should l say l am a nurse and a Roman Catholic? This may sound ridiculous, but l

find it puzzling.

I work in a large hospital with 13 operating rooms, and have been confronted by my superiors for refusing to participate in therapeutic abortions. Because of a shortage of staff, I have been informed that this "little whim" of mine cannot be accommodated.

I have been practically ordered not to pull stunts like this again! Obviously, something that is of great importance to me, something that is against all my religious convictions, is nothing

but a capricious fancy.

The essence of nursing is to help conserve life. True, the world is changing and nursing must keep up with events, but has it changed so drastically as to destroy a person's dignity? Is this what all those years of education and experience amount to? Is it because doctors decide who should or should not live that the nurses' responsibility is to be an accomplice to murder? Yes, murder, for that is what it really is.

If patients can obtain an abortion, surely they can easily find ways of preventing conception, or doesn't life

begin at conception anymore?

Am I a poor nurse because I value life so much? Do I deserve to be ostracized for having a conscience and a strong personal feeling that an unborn child has the right to live?

As an operating room nurse, is my responsibility to the woman having an abortion, taking the unborn child for granted as if it were not at all human but a thing? — RN, Alberta (name withheld on request).

**Emphasis** in nursing changes

In recent years there has been a changing emphasis in nursing. When nursing education took place in hospitals, there was a structured approach to students and patients, involving long hours of what is now called "service."

If hospital staffs were reduced a little and were coordinated with the teaching agency, extra experience might benefit a student who has an experienced teacher with her. There would be some relief for the hospital nursing budget, and the student self-concept and sense of responsibility would be enhanced.

In the transition of nursing education from hospitals to colleges, there has been decreasing concern for the patient. There are still, of course, many nurses who work devotedly to give good care.

The confusion in health services has had an impact on hospital nurses and nursing teachers. We are all caught in many cross-currents of ideas, job demands, and constant changes. As professional nurses, we have been taught to give patients good care. This implies responsibility, which many have abandoned

We owe it to each patient to give optimum care. We do not need nursing care plans or written orders for everything we do for a patient, but we need initiative, thoughtfulness, and purpose.

Our focus should be the patient—but is it? Why do we see patients with pressure sores or with badly coated tongues? Why do patients say: "I haven't had my back or feet washed since your student was here three or four days ago?" Why are trays, with the cutlery unwrapped and the tea not poured, put in front of elderly and weak patients? Why do patients who are dying, are in pain, or hesitate to complain, have to endure so many hours without sedation?

Students see the attention people need when they are ill. How can we teach them to maintain their sense of integ-

rity and responsibility?

Nursing a patient on a general floor involves care we would want for our families or ourselves. Everything we do for a patient is "service." We are there to support him, care for him, teach him, and rehabilitate him if we can. — RN, Ontario (name withheld on request).

#### Advice for nurses in NWT

The Northwest Territories Registered Nurses Association is a voluntary organization, presently operating with a steering committee of six members.

The Nurses Ordinance, passed in January 1973 by the NWT Territorial Council, has no regulations and so is not yet operational. When this ordinance comes into effect, nurses in the NWT will have to obtain a licence to practice before working as RNs.

All nurses will be informed when it is necessary to become licenced in the NWT. In the meantime, nurses working in the NWT are advised to keep their provincial registration current.—

Jeanette Plaami, secretary, steering committee, NWT Registered Nurses Association, Yellowknife.

Next Month in

#### The Canadian Nurse

- A Glimpse of Nursing in Cuba
- Cardiac Surgery in the First Person
- Diseases Encountered in the Tropics
- Clinical Nurse Specialist
   A Report



### Photo credits for August 1973

Julien LeBourdais, Toronto, p. 7

Island Information Service, Charlottetown, P.E.I., p. 13

W. VanKirk Buchanan, Mexico City (Courtesy of the American Journal of Nursing), pp. 17-28 and cover photo.

National Research Council, Ottawa, pp. 29-32

# Who makes surgeons' gloves for the giants of skill who are small in stature and wear size 5 1/2



Perry!...Naturally! But why? —Because small in stature doesn't mean small in the appreciation of proper fit and other features and benefits that have made Perry the most widely used latex surgeons' gloves—in any sizel Like all Perry Latex Surgeons' Gloves, size 5½s have beaded wrists for added protection and strength, whisper thin palms to lessen hand fatigue, exclusive Dermashield® process that provides a durable hypo-allergenic finish and packaging to fit your preferred dispensing technique. If you'd like a sample of Perry Latex Surgeons' Gloves, please write us. By the way, you don't have to wear size 5½, we'll send you the size gloves that fit you.



AFFILIATED MEDICAL PRODUCTS LIMITED
90 Commercial Ave., Ajax, Ontario

#### news

#### **CNA Demonstration Nursing School** Celebrates 25th Anniversary

Windsor, Ont. — Graduates of the Metropolitan (Demonstration) School of Nursing, which was the brainchild of the Canadian Nurses' Association, recently celebrated the 25th anniversary of the school's founding.

CNA "conceived the idea of the demonstration school, made its establishment possible, organized it, and was responsible for its administration. The Canadian Red Cross provided most of the financial support," according to an evaluation report on the school, written by A. R. Lord in 1952.

The Metropolitan School opened on January 9, 1948 and closed in September 1952. Eighty-seven nurses graduated in the four classes of the school's two-year program. Forty-three of these graduates and one teacher, Margaret McPhedran, met in Windsor for the reunion dinner on June 16, 1973.

Dr. Helen K. Mussallem, executive director of CNA, represented the association at the celebration; Dr. Helen McArthur Watson, president of CNA at the time of the Metropolitan demonstration and, later, nursing director of the Canadian Red Cross, represented the Red Cross.

"This demonstration school and the evaluation report (Lord Report) led the revolution of nursing education in North America," Dr. Mussallem told The Canadian Nurse.

"Looking back, the Metropolitan School and its evaluation may have been one of the most significant things CNA has done. The evaluation gave a strong base for subsequent studies and a great push to get nursing education into the general education stream. It pointed the way to reform in nursing education," she said.

The records of students from the Metropolitan School are kept at CNA House. "We send out transcripts, just as any nursing school does," Dr. Mussallem said. "CNA is, in effect, the alma mater of the Metropolitan graduates."

Information about Metropolitan graduates, gathered by an alumna, showed that 45 of the school's graduates are presently active in nursing practice. Contact is maintained with 84 of the 87 graduates; one is dead, and contact has been lost with two.

Graduates came to the 25th anni-



Queen Elizabeth stopped to speak to some of the nurses from Mount Sinai Hospital and the Nightingale school of nursing during her June visit to Toronto. The Queen unveiled a plaque at Mount Sinai Hospital, marking the opening of the new hospital building.

versary from across Canada, including nurses from British Columbia and New Brunswick; two came from the USA and one each from Africa, Taiwan, and New Guinea.

**ANPQ Goals Reflected** In New Quebec Legislation

Quebec City — The Code of the Professions and the Nurses' Act, passed by the Quebec legislature in July, contain all the recommendations made by the Association of Nurses of the Province of Quebec (ANPQ).

Under the new Nurses' Act, the ANPQ has control of admission to nursing education programs.

Under the new professional code, professional associations and the Quebec ministry of education are jointly responsible for education.

The extended role of the nurse is protected by the new definition of nursing. The ANPQ wanted the definition to include the right to "teach" clients, but the new law gives nurses the responsibility for "informing" them.

The annual meeting of the ANPQ will continue to make decisions by an assembly of voting delegates — one delegate for every 75 members rather than through universal suffrage, as the code had originally proposed.

A report of ANPQ positions on issues in the legislation appeared in News, June 1973, page 10.

Rachel Bureau, president of ANPQ, said of the new laws, "The legislators have given us the tools; if nurses want to, the scope of their work can be enormously enlarged."

First RNAs Elected To Council Of Ontario College Of Nurses

Toronto, Ont. - For the first time in the 10-year history of the College of Nurses of Ontario (CNO), registered nursing assistants elected their representatives to the council of the College recently. The College of Nurses is the statutory body responsible for standards of education and practice of RNs and RNAs in Ontario.

Sixteen RNs and seven RNAs were elected to the council to represent the six regions of the province for a threeyear term that began in June 1973. Over 69,000 registered nurses and over 24,000 registered nursing assistants elected council members for their

respective groups.

Prior to this election, the council had one representative of the RNAs, appointed by the Association of Ontario Registered Nursing Assistants. The Registered Nurses' Association of Ontario appointed four members to previous councils; the RNAO has no appointees on the new council.

RNAs are not yet members of the CNO but government legislation to extend membership to them is before

the Ontario legislature.

In a brief presented to the Ontario government in May 1972, two CNO recommendations were that all nurses and all nursing assistants granted certification by the College should be members of the College, and that all members of the College should elect representatives from among their members to serve on the CNO council, along with lay representatives. (News, June 1972, page 11.)

#### **CNF Members Elect Directors** And Delete Committees

Ottawa - At the annual general meeting of the Canadian Nurses' Foundation (CNF), held in CNA House on June 7, nine nurses were elected to the board of directors. By a bylaw change approved at the meeting, these directors will serve a one-year term so that, beginning in 1974, the CNF directors' term of office will coincide with that of the CNA directors; from 1974 on, the CNF term will be two years.

Those elected were. Beverly Du Gas, Ottawa; Gay Engensperger, Vernon, B.C.; Roseanne Erickson, Calgary; Dorothy Gill, Halifax; Denise Lalancette, Sherbrooke; Fay McNaught, Winnipeg; Joyce Nevitt, St. John's;

Marilyn Riley, Halifax; and Appolline Robichaud, Fredericton.

Members present at the annual meeting approved the deletion of two standing committees: finance, and education and publicity. The selections and research committees were retained.

The board decision to rescind a motion from the 1972 annual meeting was ratified. (News, December 1972,

Ten CNF fellowships, with a total value of \$31,500, have been awarded for 1973-74: nine for study at the master's level and one for doctoral study. Names of the recipients will be published in the near future. In the 11 years of the CNF's existence, 144 academic years of graduate study have

been supported.

The CNF secretary-treasurer, Dr. Helen K. Mussallem, said in her annual report: "The viability of CNF is dependent on a few nurses with a large commitment . . . Correspondence reveals that many of these nurses have never had - nor will have - the opportunity to engage in graduate study. But they believed in the goals of the Foundation and because of them it is alive and well and living in Canada."

Eleven members of the CNF, including the president, Geneva Purcell, attended the annual meeting; six came from outside Ottawa, one from Ottawa, two were CNA staff, and two were CNF staff. It was uncertain for a time whether attendance would reach the necessary

quorum of ten.

The next CNF annual general meeting will be held during the 1974 CNA annual meeting and convention in Winnipeg in June.

It's Winnipeg In '74



The Gateway to the West swings both ways - join nurses from across Canada at CNA's annual meeting and convention in Winnipeg, June 16 to 21, 1974. There is murky water (Cree meaning of Winnipeg) at the juncture of the Assiniboine and Red Rivers, but if you can see your way clear to come, you'll have a "buffalo of a time!" (No whales in the Red River!)

Nurses In B.C. Civil Service **Receive Salary Increases** 

Vancouver, B.C. - Some 1,800 registered and psychiatric nurses employed in the British Columbia civil service have received salary increases retroactive to April 1, 1973.

Nurses who earned less than \$750 a month received a \$75-a-month salary increase, and those who earned more than \$750 received an increase of 10 percent. The government also agreed to increase nurses' night responsibility

pay from \$5 to \$15 a month.

Nora Paton, director of personnel services for the Registered Nurses' Association of British Columbia, and Dwight Wenham, executive secretary of the B.C. Psychiatric Nurses' Association, met with the Provincial Secretary in May.

First Nurses' Strike In Alberta **Ends With 24.7 Percent Pay Increase** 

Calgary, Alta. - Public health nurses employed by the city of Calgary went on strike May 31 after the city rejected a conciliation board majority award. The nurses had accepted the majority award, but the City accepted the minority decision made by its appointee to the board.

On the first day of their seven-day strike — the first by nurses in Alberta — the nurses set up picket lines at City Hall and at city installations. At City Hall, the major picket line of some 40 nurses kept most employees from re-porting for work. That day, approximately 900 city employees stayed away

Support for the nurses came from city workers even though the nurses indicated they were not asking other unions for help. The work stoppage by the city employees lasted only one day, but some union spokesmen hinted at further action if the strike continued.

The collective bargaining dispute that led to the strike resulted from the city's salary offer, which was 1.5 percent below the conciliation board's award and would have meant lower rates at the end of the contract. Another sore point was that the public health nurses were among the lowest-paid in Alberta.

Lynn Skillen, chairman of the nurses' negotiating committee, summed up the situation after seven days of striking, when the nurses were considering the city offer of 24.7 percent over three

years.

"Our efforts have been effective, but the longer we strike, the less effective we are. We all want an acceptable settlement, but we must recognize . . . there has to be face-saving on both sides, Ms. Skillen said.

"The proposal represents an alternative to the fixed positions of both sides. Only as a means of reaching a settlement, we suggested a change in the length of the contract. The city said OK...36 months....

"On the positive side, there is some catch-up with the rural health units involved in the proposal. The end of the contract leaves us in the second year of other city contracts and this could be to our advantage," Ms. Skillen told the nurses on strike.

She added that the experience the nurses gained during their negotiations would be effective in the next round of bargaining. The strike vote was 70 to 7 in favor of accepting the city's offer.

Under the new contract, a public health nurse I with a degree will receive a salary, retroactive to January 1, 1973, between \$681 and \$873 a month. As of January 1, 1974, the salary will range from \$729 to \$934; beginning January 1, 1975, it will range from \$865 to \$1,107.

The Calgary public health nurses provide family services, provide health services to the city's schools, make home visits, teach nursing students, and conduct baby and immunization clinics.

#### Nipawin Nurses' Association Case Argued Before Supreme Court

Ottawa — The case involving a Saskatchewan staff nurses' association's application for certification as a collective bargaining agent was heard by five judges of the Supreme Court of Canada June 18. The appeal to this court was made by the union opposing the nurses' application.

Lawyers for the Service Employees International Union (SEIU) and for the Saskatchewan Registered Nurses' Association repeated the arguments that were given before the Saskatchewan labor relations board in the fall of 1972 and the subsequent hearing by the province's Court of Appeal (News, June 1973, p. 16). The board's decision to dismiss the application was overturned by the court, which instructed the board to rehear the case according to law.

SEIU lawyer George Taylor backed the board's decision to dismiss the application on the grounds that the Nipawin association was dominated by SRNA. Under the Saskatchewan Trade Union Act of 1972, any organization considered "company-dominated" cannot qualify as a trade union.

The Trade Union Act defines a company-dominated organization as a labor organization whose formation or administration has been dominated or interfered with by an employer or employer's agent or who has received

#### ICN Code For Nurses: Ethical Concepts Applied To Nursing

The fundamental responsibility of the nurse is fivefold: to promote health, to prevent illness, to restore health, to alleviate suffering, and to create a spiritual environment.

The need for nursing is universal. Inherent in nursing is respect for life, dignity, and rights of man. It is unrestricted by considerations of nationality, race. creed, color, age, sex, politics, or social status.

Nurses render health services to the individual, the family, and the community, and coordinate their services with those of related groups.

Nurses and People

The nurse's primary responsibility is to those people who require nursing care. The nurse, in providing care, respects the beliefs, values, and customs of the individual.

The nurse holds in confidence personal information and uses judgment in sharing this information.

Nurses and Practice

The nurse carries personal responsibility for nursing practice and for maintaining competence by continual learning.

The nurse maintains the highest standards of nursing care possible within the reality of a specific situation.

The nurse uses judgment in relation to individual competence when accepting and delegating responsibilities.

The nurse, when acting in a professional capacity, at all times maintains standards of personal conduct that reflect credit upon the profession.

Nurses and Society

The nurse shares with other citizens the responsibility for initiating and supporting action to meet the health and social needs of the public.

Nurses and Co-Workers

The nurse sustains a cooperative relationship with co-workers in nursing and other fields.

The nurse takes appropriate action to safeguard the individual when his care is endangered by a co-worker or any other person.

Nurses and the Profession

The nurse plays a major role in determining and implementing desirable standards of nursing practice and nursing education.

The nurse is active in developing a core of professional knowledge.

The nurse, acting through the professional organization, participates in establishing and maintaining equitable social and economic working conditions in nursing.

This amended version of the Code proposed by the professional services committee of the ICN was approved by the Council of National Representatives at the 15th quadrennial congress in Mexico City in May. The finalized version will be published in the near future by ICN.

Ingrid Hämelin, Finland, chairman of the professional services committee for 1969-73, noted that the Code approved in 1965 had reference, in the introductory statement, to the Human Rights declaration and the Geneva Convention. "These do not appear in the new Code. They are too important not to be officially adopted by the ICN. The Declaration of Human Rights was adopted in Dublin in 1971."

Canada moved that the CNR endorse the Red Cross rights and duties of nurses under the Geneva Convention of August 1949. The motion was carried.

financial or other support from an employer or its agent. An employer's agent is defined as a person or association acting on behalf of an employer.

Mr. Taylor said SRNA includes many nurses performing functions that are managerial in character, and a collective bargaining agent (in this case, the Nipawin association) must be independent of employers' influence.

But the crucial question, he told the judges, was whether the labor relations board had the right to make the decision it made with regard to the Nipawin application. He argued that the board had the right to be wrong, and its decision could not be overruled. (The Trade Union Act says there is no appeal from the board's orders or decisions.)

SRNA lawyer Donald MacPherson contended that the labor relations board went outside the jurisdiction of the Act since the board did not say that any members of SRNA's council were acting on any employer's behalf. He added that evidence showed this was not the case.

(Continued on page 12)



A close examination of the entire spectrum of nursing, this thoroughly revised edition correlates nursing arts and basic science knowledge with clinical nursing. Expanded chapters on medical-surgical nursing and pediatric nursing now encompass pertinent material on communicable diseases and orthopedics. A broader view of rehabilitation nursing replaces restorative care. The fundamentals of nursing chapter has been completely revised to include material on: basic concepts of health; the changing of health care systems; the problem-solving process; the planning, implementation, and evaluation of nursing care; and basic nursing procedures.

By an editorial panel of 12, September, 1973, 8th edition, approx. 632 pages, 7¼" x 10½", 44 illustrations, About \$11.05.

A New Book!

Douglass

#### Review of Team Nursing

(Mosby's Comprehensive Review Series)

The easily understood question and answer format gives students an opportunity to assess their responsibilities in team oriented care. In the section dealing with emergence of nurse leaders, the necessary personal qualifications as well as the mechanics of effective leadership are noted along with recommendations for delegation of responsibility. An analysis of group processes, evaluation processes and systems of communication confirms the advantages in nursing care which result from successful utilization of team concepts.

By LAURA MAE DOUGLASS, R.N., B.A., M.S. September, 1973. Approx. 176 pages, 5½" x 8½". About \$5,20.

New Volume IV!

# Current Concepts in Clinical Nursing

Nursing comes alive for students in articles dealing with the most vital and current topics in psychiatric, pediatric, maternity, and medical-surgical nursing. The psychiatric nursing section identifies major problems confronting nurses in this field and discusses the nurse as a therapeutic agent working with persons in other health disciplines. Implications for all phases of the life-cycle are explored in the maternity nursing section, including such topics as the abortion controversy and the nurse and human sexuality. The medical-surgical section features articles on patients with thermal and cervical cord injuries and legal aspects of nursing. Pediatric nursing articles emphasize the need to work with children in their total family situation.

Edited by EDITH H. ANDERSON, R.N., Ph.D.; BETTY S. BERGERSEN, R.N., Ed.D.; MARGERY DUFFEY, R.N., Ph.D.; MARY LOHR, R.N., Ed.D.; and MARION H. ROSE, R.N., Ph.D.; with 43 contributors. October, 1973. Approx. 448 pages, 7" x 10", 37 illustrations in 29 figures, About \$17.80.

INSTRUCTOR'S NOTE: To receive a complimentary copy for firsthand evaluation, write to the Textbook Department mentioning your position, course and enrollment.

# Satisfy a healthful curiosity.

Seven texts answer the critical questions of tomorrow's nurses.

New 7th Edition!

Griffin-Griffin

A New Book!

Dubay-Grubb

# History and Trends of Professional Nursing

This updated version of a classic enables students to view nursing's latest trends in historical perspective. Emphasizing the evolutionary role of women in today's society, the authors offer new discussions on: "female liberation"; abortion laws; legal aspects; research; the ladder concept; continuing education in nursing; the "nurse practitioner"; and more. A new insert on the nurse's right to attend college under the G.I. Bill of Rights is included as well as new material on university and college schools of nursing, accreditation for junior colleges, and the American Association of Deans of College and University Schools of Nursing. Ten new biographical sketches provide valuable insight into nursing history.

By GERALD JOSEPH GRIFFIN, B.S., M.A., Ed.D., R.N.; and JOANNE KING GRIFFIN, B.S., M.A., R.N.; with a special unit on Legal Aspects by ROBERT G. BOWERS, B.A., J.D. July, 1973. 7th edition, approx. 384 pages, 7" x 10", 62 illustrations. A bout \$9.45.

## Infection: Prevention and Control

Students gain a working knowledge of infection prevention and control in this well-written guide. It backgrounds students in basic microbiology and epidemiology and presents commonsense policies and procedures for development and maintenance of a complete infection control program. Emphasizing the nurse's supervisory role in infection control, the authors convey valuable information on data collection and interpretation as a basis for assessing need and problem areas. Other important discussions include: meeting the isolation patient's emotional needs; legal aspects of hospital associated infections; and education programs for the health facility's staff.

By ELAINE C, DUBAY, R.N., B.S.; and REBA D. GRUBB, Medical Writer, Consultants: RUDOLF G, WANNER, M.D., M.P.H. & T.M.; MARY FRIED, Ph.D.; and TONY MAZEL. August, 1973. Approx. 144 pages, 6" x 9", 40 illustrations by TRAVIS L. MAYHALL. About \$5,00.

A New Book!

McInnes

Cherescavich

## Controlling the Spread of Infection

A Programmed Presentation

Requiring no prior knowledge of microbiology, this new book lays the groundwork for infection prevention and control in an easily understood programmed learning method. The author briefly presents basic information on sources of infection; the interrelationship between microorganisms and the human host in health and disease; the modes of transmission and portals of entry; and the variables that allow micoorganisms to cause disease. Sound scientific principles of asepsis are set forth for immediate and realistic application in the everyday care of the patient. These principles are correlated with specific technical nursing skills used to control the spread of infection.

By BETTY McINNES, R.N., B.Sc.N., M.Sc.(Ed.). July, 1973. Approx. 176 pages, 7" x 10". About \$5.20.

#### A Textbook for Nursing Assistants

New 3rd Edition!

Clearly reflecting the expanding role of auxiliary nursing personnel, this new edition focuses on the nurse assistant as a team member in the health care delivery system. Pertinent specific disease mechanisms and nursing care techniques are fully explained. Students learn why a particular care is preferred to meet patient's needs, how to provide that care, and what results can be expected. This edition places new emphasis on the use of disposable equipment and presents an updated section on isolation. The text includes valuable self-help aids such as chapter study and discussion questions, a glossary of terms and sources of additional information. A helpful teaching guide is included.

By GERTRUDE D. CHERESCAVICH, R.N., B.S., M.S. June, 1973. 3rd edition, 442 pages plus FM 1-XII, 7" x 10", 179 illustrations. Price, \$10.00.



#### news

(Continued from page 9)

Another reason Mr. MacPherson gave for the board's stepping outside its jurisdiction was that it asked the wrong question. He said the board had asked whether SRNA helped with the formation of staff nurses' associations. This was irrelevant, he said, unless SRNA or its council was an employer or an employer's agent.

Mr. MacPherson noted that SRNA openly helped with the formation of staff nurses' associations, including the Nipawin association, because members of SRNA had asked for this

The SRNA lawyer also criticized the labor relations board's statement that an organization applying for certification "must be a genuinely independent body in all respects." He said that if that statement were law in the province, no local of a national or an international union could be certified.

In 1968, SEIU was certified as a trade union for employees, excluding registered nurses, at Nipawin Union Hospital. But with the new Trade Union Act of 1972, members of professional associations could no longer be excluded from a collective bargaining unit, as had been the case in Saskatchewan until

The Nipawin nurses' application was the first in Saskatchewan to be opposed by another union on the grounds of company-domination. Regina Pioneer Village Staff Nurses' Association, which applied for certification on its own behalf and completely independent of SRNA, was opposed by the Canadian Union of Public Employees, but for different reasons.

Although CUPE's challenge was based on the size of the unit and the classification of employees, the labor relations board asked the Pioneer nurses' association to provide evidence that it was not company-dominated. The nurses' association received its certification order in March 1973.

Nine other staff nurses' associations in Saskatchewan were certified before the Nipawin association applied for certification. Until the Nipawin case is resolved, 13 pending applications by staff nurses' associations have been adjourned by the labor relations board.

The outcome of the Nipawin case could affect nurses in provinces with legislation similar to Saskatchewan's. Only the British Columbia and Alberta registered nurses' associations have the right to collective bargaining in

their nursing acts.

August 27 is the earliest date that the Supreme Court decision will be handed down.

**Canadian Nurse Admitted** To Nurse Researchers' Group

Ottawa, Ont. — Pamela Poole, nursing consultant in the hospital services study unit, Health and Welfare Canada, has become a member of the Council of Nurse Researchers of the American Nurses' Association.

The council, which has about 450 members, was formed in 1971. A nurse wishing to join the nurse researchers' group must have her research credentials approved by a five-member committee.

The council's first conference will be held August 22 to 24 in Denver, Colorado. Topic of the three-day conference is "Issues in Research: Social, Professional, Methodoligical."

Committee On Education Of Nurses Named To Advise NBARN Council

Fredericton, N.B. — The New Brunswick Association of Registered Nurses and the N.B. minister of health have named a committee to advise the NBARN Council on all matters related to the education of nurses, including the approval of nursing schools.

Included on the advisory council are nurses, and physician, administrator, general education, and consumer representatives. Seven nurses have been appointed by the NBARN Council. Four nonnurses have been appointed by the minister of health from nominees submitted by the New Brunswick Hospital Association. The New Brunswick Medical Society has one nominee on the council.

According to NBARN spokesman Appoline Robichaud, this committee represents one step in a series of organizational reforms in the association. "The purpose of these changes is to acknowledge public involvement in nursing activities where the public interest is at stake."

Ms. Robichaud pointed out that public representation had already been added to some committees and to NBARN's governing body (News, May 1973, p. 15). She added that this trend will continue in the next year as "NBARN changes its standing committee structure to accommodate the advisory committee on the education of nurses and an advisory committee on regulation and professional practice, which will soon be established.

"We feel these changes will be of great benefit to the public we serve and to the quality of service provided by nurses," said Ms. Robichaud.

The new advisory committee held its first meeting in Fredericton April 26 and 27. In addition to holding an orientation workshop, the committee's first major task is to review proposals for the new two-year Ecole de formation infirmière d'Edmundston, with a view to approving the educational program.

The nurses named to the committee are Shirley Dunphy and Irene Leckic, Fredericton; Marianne Schwarz, Bathurst; Sister Germaine Preston, Moncton; Carmen Dion, Edmundston; and Barbara Phillips and Emily Mitchell,

Saint John.

Nurses Will Be Most Affected By Community Health Centers **Professor Tells SRNA Meeting** 

Yorkton, Sask. — The nurse probably will be affected more than anyone else if the community health center concept becomes the primary ambulatory care unit in Canada.

This prediction was made in June by Dr. V.L. Matthews, professor and head of the department of social and preventive medicine at the University of Saskatchewan in Saskatoon. He was speaking about the community health center to the 275 nurses at the annual meeting of the Saskatchewan Registered Nurses Association.

To illustrate his point, Dr. Matthews referred to Quebec, "where they propose to develop ambulatory care through community social service centers and to de-emphasize hospital care. Their plan . . . proposed the closure of 30,000 of the existing 60,000 hospital beds in the province." If this happens, he said, a large number of nurses will be considering new careers in ambulatory care facilities.

With the development and expansion of the community health center concept, Dr. Matthews noted a number of impli-

cations for nurses:

• There will be increasing recognition of nursing as an independent professional service involved in ambulatory care; this will include the nurse's role in home care, the public health nurse role, and the nurse-clinician role.

• There will be much more involvement of the nurse in group practice, where she will become a member of the preventive, diagnostic, therapeutic, and

rehabilitative team.

• There will be a greater demand for inter-professional communication and understanding.

 More emphasis will be placed on community nursing and on counseling and educational skills, with less emphasis on technical matters and institutions.

 An increased social orientation will be emphasized more than technology. Nurses will be asked increasingly to help people with problems instead of treating illness with tender loving care.

• Recognition of the nurse practitioner is only the beginning of a trend away from hard-and-fast professional lines.

• Nurses will be expected to accept new groups of co-workers; these will include patient advocates, community health workers, and some "plain trouble makers."

• Nurses will find more opportunity for promotion and for exercising control. The dominant person and the leader in the community health center

may be the nurse.

• Nursing will likely become "a major countervailing force to the medical profession in influencing public policy. In my view, this would be good for both professions."

 Nurses will be expected to expand their role in task forces and study groups, and take a political stance on

issues.

• Nurses will be called on to work more effectively with the general public and with public bodies. They must develop more understanding of the attitudes and opinions of the public.

Dr. Matthews concluded by telling the nurses they must seriously consider the kind of health center they want: Should it be based on a medical or a social model? Who should control it — the professions, the public, or a combination of them? On what basis should it be organized — provincially, regionally, locally, or on a laissez-faire basis?

In theory, he said, "the proposals for community health centers represent . . . a real opportunity to introduce some democracy into the health service. In practice, little has happened. . . .

"The community health center will continue to be an illusion to a great majority of Canadians unless there are major changes in provincial initiatives in planning and finance."

#### **Expanding Role Of Nurses Stressed At RNABC Meeting**

Vancouver, B.C. — British Columbia Health Minister Dennis Cocke endorsed the concept of an expanded role for nurses in the provision of health care during his address at the annual meeting of the Registered Nurses' Association of B.C. May 23 to 25.

But at the same time, Mr. Cocke warned he would have to accept the expanding role of other disciplines. Announcing the June 1, 1973, proclamation of the B.C. Registered Psychiatric Nurses' Act, he said registered psychiatric nurses "have a very important role to play in terms of extending into the hospital and into the community"

Mr. Cocke said that integrating

**AUGUST 1973** 

#### First Men Trained As Nursing Assistants In P.E.I.



Traditional female territory in PEI gave way to men's liberation this year when Robert Lutz and Wayne Gillespie became the first males to train at Charlottetown's central school for nursing assistants. In the photo, Wayne checks the blood pressure of fellow student Robert while their instructor, Noreen Connolly, looks on. The two men began work as nursing assistants at Hillsborough Hospital, Charlottetown, after graduation in May 1973; they were employed as attendants at Hillsborough prior to passing the civil service examinations that enabled them to take the course while receiving an attendant's salary.

mental health services into the whole health care system would involve bringing psychiatric nurses into the mainstream.

A record attendance of more than 700 at the annual meeting included guests from the Psychiatric Nurses' Association.

The health minister also stressed the importance of preventive care and public education to develop fitness. He announced he had asked a former B.C. registered nurse, Mitzi Montgomery, to study the fitness aspect of health services in Norway and Denmark and report to him. Ms. Montgomery is a doctoral candidate at the University of Edinburgh in Scotland.

Another speaker, Dr. Richard G. Foulkes, reminded the nurses that the licensing function is delegated to professions by the state. Dr. Foulkes, director of the B.C. government's Health Security Program Project, spoke on the topic "A Partnership in Health Core".

He said the state must become a real partner in health care, rather than remain the body at the top of a pyramid. The state must concentrate on policy decisions and delegate operations to the community, he added.

Dr. Foulkes concluded: "Let our deliberations on the matter of partner-ship not dwell solely on that between professionals. Such deliberations must include much more consideration of the involvement of the people and the state."

Dr. Helen K. Mussallem brought greetings to the RNABC meeting from the Canadian Nurses' Association. The CNA executive director told the audience that nursing is alive and not suffering from future shock.

Dr. Mussallem noted: "We now wear future shock absorbers. Today is the tomorrow we feared yesterday when we read Toffler in 1970. Diversity, rapid change, and extension of roles have produced an air of anticipation in all areas of nursing."

Voting delegates at the meeting passed a number of bylaw amendments and five resolutions. One resolution dealt with the shortage of nurses for positions above the general duty level. It asked

(Continued on page 15)

Vew Duotone Design MRS. R. F. JOHNSON SUPERVISOR CHARLENE HAYNES MRS. HOLBRUUN ANN COHN, L.P.N.

Vame Pins 'n Things...from Reevel

#### IT'S EASY TO ORDER REEVES NAME PINS FOR YOURSELF OR FRIENDS!

Choose style you want, shown left. Print name (and 2nd line if desired) on dotted lines below. Check other info in boxes on chart, clip this section and attach to coupon

bottom left. Attach extra sheet for additional pins NOTE SAVINGS ON 2 IDENTICAL PINS . . . more convenient, spare in case of loss.

COLOR (Plastic) PRICES\* DESCRIPTION Engraved | Line | Engraved 2 Lines ALL METAL . . . rich, trim and tailored. Lightweight, smooth edges, rounded corners. Black
Dk. Blue
White Does Duoto ☐ 1 Pin 1.98 ☐ 1 Pin 2.58 2 Pins 3.25 2 Pins 3.85 ☐ Silve Satin apply PLASTIC LAMINATE White Black PLASTIC LAMINATE . . . slimmer, broader; engraved thru surface to contrasting core color. Beveled border matches lettering. Does not apply ☐ 1 Pin .95 ☐ 1 Pin 1.45 ☐ 2 Pins 1.65 ☐ 2 Pins 2.30 Med. Green Med. Blue Cocoa 559 not apply 100 MOLDEO PLASTIC...Simple, smart economical. Will never discolor. Smooth rounded corners and edges 1 Pin .95 1 Pin 2 Pins 1.65 2 Pins 510

\*Please add 25¢ per order for 3 pins or less.

QUANTITY DISCOUNTS: 10-24 pins, deduct 10% 25-99 pins, 15%; 100 or more pins, 20%



SCOPE SACK neatly carries and protects Nursescope or any scope. Double-thick frosted flexible plastic, white vinyl binding. 41%" x 942". Your own initials help prevent loss. No. 223 Sack. . . 1.00 es. G or more 75¢ ea. Your initials gold-stamped, add 50¢ per sack.

#### NURSES PERSONALIZED ANEROID SPHYG.

ANCROUD SPITU.

A superb instrument especially designed for nurses! Imported from precision craftsmen in W. Germany. Easy-to-attach Velore outfl. lightweight, compact, fits into soft sim. leather zippered case 2½" at "x "7". Dia Calibrated to 320 mm., 10-year accuracy guaranteed to -23 mm. Serviced by Reeves if ever required. Your Initials engraved on manometer and gold stamped on case FREE, for permanent identification and distinction. A wise investment for a lifetime of dependable service!

No. 106 Sohye. . . 32.95 ea. No. 106 Sphyg. . . . 32.95 ea.



MEDI-CARD SET Handiest reference ever! 6 smooth plastic cards (3½" x 5½") crammed with information, including Equivalencies of Apothecary to Metric to Household Meas, Temp. °C to °F, Prescrip, Abbr., Urinalysis, Body Chem. Blood Chem., Liver Tests, Bone Marrow, Disease Incub. Periods, Adult Wgts, Child's Dosages, etc. All in white vinyl holder with gold stamped caduceus. No. 289 Card Set . . . 1,50 ea. 6 or more 1,25 ea. 12 or more 1,10 ea. Your initials gold-stamped on holder, add 50¢ per set.



KELLY FORCEPS So handy for every nurse! 5½" stainless steel, fully guaranteed. Ideal for clamping off tubing. Your own initials help prevent loss.

No. 25-72 Forceps . . . 2.75 ea. S or more : Your initials engraved, add 50¢ per forceps.



#### CAP ACCESSORIES

CLAN CAP TOTE keeps your caps crisp and clean while stored or carried. Flexible clear plastle, white trim, zipper, carrying strap, hang loop. Stores flat. Also for wiglets, curiers, etc. B½" dla, 8" high.

No. 333 Tote . . 2.65 ea., 6 or more . . 2.35 ea. Your initiels gold-stamped, edd 50¢ per Tote.



WHITE CAP CLIPS firmly in place! Hard-to-find white bobbie pins, enamel on fine spring steel. Eight 2" and eight 3" clips included in plastic snap box. No. 529 Clips . . 3 boxes for 1.95, 6 for 3.25, 12 for 49; ea.

#### MOLDED CAP TACS

Replace cap band instantly. Tiny plastic tac, dainty caduceus. Choose Black, Blue, White or Crystal with Gold Caduceus; or all Black (plain). The neater way to festen bands. No. 200 Set of 6 Tacs . . . 1.25 per set. 12 or more sets 1.00 per Set



METAL CAP TACS Pair of dainty jewelry-quelity Tacs with grippers, holds cap bands securely. Sculptured metal, gold finish, approx. 3-h" wide. Choose RN, LPN, LVN, RN Caduceus or Plain Caduceus. Gift boxed. No. CT-1 (Specify Initials), No. CT-2 (Plain Cad.) or No. CT-3 (RN Cad.) . . . 2.95 pr.

SEL-FIX CAP BAND Black velvet DELFTIA CAF DARIU Black vervet band material. Self-adhesive, presses on, pulls off; no sewing or pinning. Reusable several times. Each band 20" long, pre-cut to popular widths: ¼" 112 per plastic box) ½" (8 per box) ¼" (6 per box) 1" (6 per bbx). Specify width under ITEM column on coupon. No. 6343 Band. . . 1.75 per box



100	No. 6343 Band 1.75 per box 3 or more 1.50 ea.					
	TO: REEVES COMPANY, Box C . Attleborg Mass 02793					
	ORDER NO. ITEM COLDR SIZE QUANT. PRICE					
n						
E.						
П	Use extra sheet for additional items or orders.					
	INITIALS as desired: (Good idea for distinctive identification)					
	TO ORDER NAME PINS, fill out all information in box top right, clip out and attach to this coupon.					
	l enclose \$(Mass. residents add 3% S. T.)					
	Sorry, no COD's or billing terms available					
	Send to					
_	Street					

#### Free Initials and Scope Sack with your own Littmann Nursescope!



Famous Littmann nurses' diaphragm stethoscope . . . a fine precision instrument, with high sensitivity for blood pressures, apical pulse rate. Only 2 ozs., fits in pocket, with gray vinyl anti-collapse tubing, non-chilling epoxy diaphragm. 28" over-all. Non-rotating angled ear tubes and chest piece beau-tifully styled in choice of 5 jewel-like colors: Goldtane, Sitvertane, Blue, Green, Pink.\*

FREE INITIALS AND SACK! Your initials engraved FREE on chest piece; lend individual distinction and help prevent loss. Also FREE SCOPE SACK included, worth \$1. as described above right. (Free cache not presented and the presented and sacks not personalized; add 50¢ if initials desired.) Ideal for group gifts! Note big savings on quantity orders (left).

No. 216 Nursescope 13.80 ea. ppd. 6-11...12.80 ea. 12 or more...11.80 ea. Group Discounts <u>include</u> free Initials and Sack! "IMPORTANT NEW FEATURE: New "Medallion" styling includes tubing in colors to match metal parts. If desired, please add \$1. ea. to all prices above, and add "M" to Order No. (No. 216M) on coupon.

Duty free

SCISSORS Precision-made imported forged steel.
Professional quality, Guaranteed 2 years.

BCL

31/2" LISTER MINI-SCISSORS Tiny, handy, slip into uniform pocket or purse. Choose jewelers Gold or gleaming Chrome plate finish on coupon.

No. 3500 Mini-Scissors . . . 2.75 ea.

41/2" or 51/2" LISTER SCISSORS As above, but larger for bigger jobs. Chrome finish only No. 4500 (4½") or No. 5500 (5½") Scissors . . . 2.75

51/2" OPERATING SCISSORS Stainless steel, with sharp/blunt points. Beautifully polished finish.

No. 705 OR Scissors . . . 2.75 ea. All scissors above: 1 doz. or more (any style) . . . . Your Initials engraved, add 50c per scissors. 2.00 ea.

CLAYTON DUAL STETHOSCOPE Light

pulse rate. Chromeo lead upos on 11½" bell and 1½" dellaphragm, grey anti-collapse tubing. 4 oz., 29" long. Extra ear plugs and diaphragm included. Two initials engraved free. (CD) No. 413 Dual Steth . . . . . . . 17.95 ea.

#### JEWELRY NURSES CHARMS

Finest sculptured Fisher charms, Sterling or Gold Filled (specify under CDLOR on coupon) For bracelet or pendant chain. Add to your collection! No. 263 Caduceus; No. 164 Cap; No. 68 Grad, Hat; No. B. Band. Scissors . . 3.49 ea.



14K PIERCED EARRINGS Dainty, detailed 14K Gold styles, for on or off duty wear. Shown actual size. Beautifully gift boxed.

fully gift baxed.

Birthstone Colors (specify on coupon): JAN Garnet, FEB Amethyst, MAR Aqua, APR Crystal, MAY Emerald, JUNE Alexandrite, JULY Ruby, AUG Peridot, SEPT Sapphire, OCT Rose Zircon, NOV Topaz, OEC Blue Zircon.

No. 13/297 Caduceus; No. 13/276 Cross;
No. 1/010 Gen. Cultured Pearl; No. 8/247 Birthstone

September 2018 Septem



Duty free

CDM

ENAMELED PINS Beautifully sculptured status insignia, 2-color keyed, hard-fired enamel on gold plate. Dime-sized, pin-back. Specify RN, LPN, PN, LVN, NA, or оп сопроп

No. 205 Enam. Pin 1.95 ea., 12 or more 1.50 ea.

POCKET SAVERS Prevent stains and wear!
Smooth, pliable pure white vinyl, Ideal low-cost group gifts or favors. No. 210-E (right), two compartments with flap, gold stamped caduceus . . . B for 1.50, 25 or more 20, ea. 0 No. 791 (left) Deluxe Saver, 3 compt. change pocket & key chain . . . B for 1.90, 25 or more 35, aa.



CDA

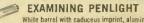
#### Nurses' POCKET PAL KIT

Handlest for busy nurses. Includes white Deluxe Pocket Saver, with 5½" Lister Scissors (both shown above). Tri-Color ballpoint pen, plus handsome little pen light all silver finished. Change compartment, key chain

No. 291 Pal Kit . . . . . . . . 4.95 e 3 Initials engraved on shears, add 50¢ per kit.

BZZZ MEMO-TIMER Time hot packs, heat lamps, park meters. Remember to check vital signs. give medication, etc. Lightweight, compact (1½-4 dis.), sets to buz 2 5 to 60 min. Key ring. Swiss made. No. M-22 Timer . . . . . . 4.95 ea. 3 or more 3.95 ea.; 6 or more 3.50 ea





White barrel with caduceus imprint, aluminum band and clip, 5" long, U.S. made, batteries included (replacement batteries available any store). Your own light, gift boxed. No. 007 Penlight . . . 3.98 ea. Your Initials engraved, add 50¢ per light.



#### w Kork-Lites Featherweight Style



#### All-Weather NURSES' CAPE



No. 65B Cape . 3 Gold Initials on collar, add 1.00 per cape.

#### BHTINGALE LAMP

thentic, unique favor, gift or engraved

!! Ceramic off-white candleholder with
ne gold leaf trim. Recessed candle
candle not included). 7" long.



100S Lamp . . 6.95 sa., 12 or more 4.95 os. Is and date angraved on gold plaque . . .





Endura NURSE'S WATCH Fine Swiss-made waterproof timepiece, Raised easy-to-read white numerals and hands on black dial, luminous markings. Red sweep-second hand. Chrome finish, stainless back. Includes black velvet stap. Gift-boxed, with 1 year guarantee. Yery dependable. Includes 3 initials engraved FREE! No. 1093 Nurses Watch . . . . . . . . . 19.95 ea.



Fast-Action TOURNIQUET Strong, lightweight Veloro\* Strap applies, adjusts and releases instantly on any limb. Positive holding power, self-adjusting tension, eliminates "pinch" For blood samples, emergencies.

Outy free

No. 2017-1 Tourniquet ... 2.69 ea.

10. 201/1 Tourney Landlie B. Havens point, with us emblem, Full name harrel (include name with coupon). ISS PEN rld-famous ballpoint, with injured caduceus emblem, Full name EE engraved on barrel (include name with coupon), fills avail, everywhere. Lifetime guarantee. 502 Chroma B.00 ea. No. 6602 12kt. G.F. 11.50 aa.

#### TRI-COLOR BALL PEN

Write in black, red and blue with one ball point pen.

I the thumb changes point (and color). Steno fine point (excellent arts). Polished chrome finish. A handy accessory for every nurse! 

HORSESHOE KEY RING Clever, unusual design: one knob unscrews for inserting keys. Fine sterling silver throughout, with sterling sculptured caduceus charm. No bead chain to break! No. 96 Kay Ring . . . . . . . . . . 4.95 ea.



#### news

(Continued from page 13)

the RNABC to study the feasibility of approaching educational institutions to establish programs to prepare general duty nurses for more senior positions. The CNA-CHA extension course in nursing unit administration was included in the resolution, as one resource that could be approached.

Voting delegates passed another resolution to encourage the federal government to enact legislation that would allow employees to retire at age 60 and still receive maximum pension benefits under the Canada Pension Plan.

**Workshop On Nurse Practitioner** Shows Cooperation In N.B.

Moncton, N.B. — In the first large gathering of its kind in New Brunswick, some 60 persons, including nurses, doctors, consumers, administrators, and representatives of universities and the provincial health department discussed the role of the nurse practitioner at a government-sponsored workshop May 4 and 5.

Objectives were to inform nurses, physicians, and health service administrators of the potential contribution of the nurse practitioner in providing primary health care; promote continuing interdisciplinary dialogue on the subject; increase public awareness of this nurse's potential role; and provide suggestions for further action.

Resource leaders at the workshop were Dr. Dorothy Kergin and Dr. Walter Spitzer from McMaster University's program for family practice nurses. A graduate of the program, Alona Eslary, was also present.

Primary care settings in which nurse practitioners could be helpful in New Brunswick were identified. They included, in addition to doctor's offices, nonserviced isolated areas, underserviced rural areas, outpatient departments and clinics, and community health centers.

Some of the points that were made during the workshop were:

• The nurse practitioner is not procedure-oriented; her emphasis is on exercising clinical judgment.

• She is not a diagnostician, but a prognostician who must know the urgency of the problems she deals with.

 New laws at this stage would be a handicap to change and would lead to inflexibility and lack of experimentation with new roles.

U. Of Sask. Nursing School **Becomes Professional College** 

Saskatoon, Sask. — The school of nursing of the University of Saskatchewan became a professional college on July 1, 1973.

Established in 1938, the school of nursing was part of the college of medicine, to which it was responsible for budget and program. As a college, it will be directly responsible to the principal of the campus and will have the same status as medicine, dentistry, pharmacy, and veterinary medicine, the other major health science faculties

of the university.

U. of Saskatchewan offers two programs leading to the bachelor of science degree in nursing. One is a four-year course for high school graduates; the other is a three-year course for registered nurses. One-year diploma programs in public health nursing, advanced psychiatric nursing, and nursing service administration are being discontinued; the basic principles are included in the registered nurse degree pro-

85 Health And Welfare Centers Closed In Quebec Since Fall, 1970

Ouebec City, Que. — The Quebec minister of social affairs, Claude Castonguay, recently made public a list of 85 public and private health and social service institutions closed since the fall of 1970, after inquiry from the ministry into their services.

In all, 2t hospitals and 64 welfare centers have been closed, up to the present, because they did not meet the standards set by the ministry, they were operating without a permit from the ministry, a regrouping of institutions took place, or the management decided to close the center.

Those who used the health or welfare centers were directed to other resources, and employees were relocated according to the collective agreements in force, the ministry said.

The Salvation Army's maternity center in Montreal, the Catherine Booth Hospital, is one of the latest Englishlanguage hospitals on which the government has announced a decision; it is to close by Oct. 15, 1973.

Katherine Stenger Frey wrote about the Catherine Booth Hospital in the article, "Childbirth Should Involve the Whole Family," published in The Canadian Nurse in August 1972. Ms. Frey praised the hospital's "real family approach to childbirth" and said it is "one that hospitals throughout Canada should consider adopting.

A committee to save the Catherine Booth Hospital has been formed in Montreal.

THE CANADIAN NURSE

# Once upon apatient.

Time was you could spend as much time cleaning surgical suction instruments as using them. But that was before Davol made them all disposable. Yankauer, Poole, Frazier, orthopedic, sigmoidoscopic. and all the tubing to connect them. They all come with the features you expect from the expensive metal ones. But priced right. For single patient use. No fuss. No recleaning. It's the Davol difference. The better way. All packed sterile in individual see-through, peelback packaging. Ask your Davol dealer salesman for details. Davol Inc., Providence, R.I. DAVOL 02901. A Subsidiary of International Paper Co.



CNA President Marguerite Schumacher and the president of the nurses of Zaire follow Zaire's flag into the ceremony that admitted the African country's nursing association to ICN membership.

pletely), and first-aiders with hard hats and walkie-talkies. Social events included Tuesday evening's Mexican Night with food, mariachi music, and dancing in the open air of Chapultepec Park, and on Thursday evening folk dances performed by a troupe of students from Benito Juarez University in Oaxaca, a city in

The 400-member Colegio Nacional

Ms. Starr is an assistant editor of The Canadian Nurse, Ottawa, Ontario.

ers' also visited places of historic and

THE CANADIAN NURSE 17



Joan Macdonald, standing, executive director of the College of Nurses of Ontario, makes a point during an international presentation at an interest session.

cultural interest around Mexico City, and shopped for silver, leather, onyx, and straw articles to take home.

#### **Business**

Is the purpose of the International Council of Nurses to assist member associations to achieve their objectives or is it the purpose of ICN to improve health by promoting nursing on a world scale? Decisions taken during the business sessions of the 15th quadrennial congress reflected a lack of confidence in ICN's ability to affect nursing conditions or, perhaps, a preoccupation with regional or national interests.

The two philosophies about the ICN's purpose and functions met head-on during debate by the Council of National Representatives (CNR). But after long, tiring sessions of amendments and motions, the idea that ICN exists to assist member associations was the winner.

On Monday morning, May 14, at the first open business session of the CNR, Margrethe Kruse, president of ICN for 1969-73, foreshadowed the issues to be discussed. She said: "In the CNR meetings we have focused on the ICN itself. Any mature organization has to take a look at itself. We have good traditions in ICN, but it is more important to be in accord with day-to-day life and have the machinery to solve day-to-day problems. We must also look ahead to influence developments.

"In order to be more influential in nursing, we are taking a look at ourselves, giving up cherished traditions, and adopting a new structure and new functions." (The new structure was only partially adopted and the new functions were rejected by the CNR.)

"It is important for the ICN... to have representation from nurses all over the world on its governing body. The board has been European-North American dominated. We have not wanted it so; it has always been possible to have representation but nurses from the younger associations have not found their way into the governing body. So the new structure will take care that we get representatives from various parts of the world on the board.

"There is a suggestion to broaden the possibility of membership in ICN. Each national association decides its own membership. Whether this will be accepted by CNR, I don't know." (It was.)

The announcement of the CNR's decision, taken at the closed session on May 12, to request the South African Nurses' Association (SANA) to take action to enable nonwhite members of SANA to serve on its board of directors, was announced at the Monday morning session. (See News, July 1973, page 7.)

Sixty-three national nursing associations, out of 74 countries in membership with ICN. had representatives voting at the meetings of the CNR. The Mexican government refused entry visas to nurses from Rhodesia and Taiwan. Nine associations were unable to send representatives to the CNR: Burma, Costa Rica, Ethiopia, Guyana, Jordan, Luxembourg, Morocco, Nepal, and Uganda.

Ms. Kruse said that 19 countries

who are in contact with the ICN were represented at the Mexico City meeting. Six of these — Bahamas, Botswana, Nicaragua, Senegal, Tanzania, and Zaire — were accepted into membership by the CNR during the business session on Tuesday, May 14.

The other groups of nurses who sent observers were Afghanistan, Antigua, Cameroons, Cuba, Cyprus, Dominica, Fiji, Grenada, Guatemala, Malta, Papua and New Guinea, St. Kitts, St. Lucia, Swaziland, and Western Samoa

In her presidential address, Ms. Kruse said that at the beginning of the 1969-73 quadrennium, 11 new associations were accepted into membership with ICN. However, all the new associations were small and they only increased the number of individual members, for whom ICN receives dues, by 0.44 percent.

"It is a sad fact that within the quadrennium, total individual membership of all ICN's 74 member associations has decreased from 543,458 to 518,285,

or by 4.6 percent," she said.

"... We have tried, through the Health Workers Union of the USSR, to get in touch with the nurses in the USSR. Since the People's Republic of China became a member of the United Nations and of the World Health Organization, we have made attempts, through the permanent delegation of the People's Republic of China in Geneva, to get some information on how the nurses in the Republic are organized. So far, no results have been obtained," Ms. Kruse said.

#### **ICN** structure

A management consultant firm studied ICN's objectives, structure, and functions, and its report was presented to the 1971 CNR meeting. (News, September 1971, page 10.) An ICN special committee was then appointed to consider this study, review comments from member associations, recommend actions that would strengthen the ICN, and prepare a report.

Before the report of the special committee was considered point by point, Margrethe Kruse invited CNR's comments on the philosophy of the special committee's suggested amendments to the constitution and regulations and on the directors' amendments to the amendments.

The United Kingdom said it could not accept the philosophy and concept in the committee's report because the report did not reflect a "radical reappraisal." It said an international body

**AUGUST 1973** 

should do things that can be done only at the international level.

Norway said the management consultants' report "had made us fear an ICN of very little help. Today it is so difficult to maintain quality of nursing service, education, and administration." The 19 functions suggested by the special committee "were a great joy to us. We need an ICN that can support the professional nurse. Norway strongly advises implementation of the special committee report."

The USA said the functions were too broad and impossible to implement. It also said any group admitted to the ICN should have a voice in the ICN. It expressed concern about the increase in dues.

Canada said that on the basis of the purpose and functions, it would support the fact that the functions as outlined could not be carried out. It could not accept the membership concept. Financial changes were also a concern to Canada.

Australia congratulated the committee. It said the broad functions were those of a national association. To carry out the functions on an international scale would require a large organization. If nurses were admitted to the national organization with full voting rights, they should have those rights in the ICN, it said.

South Africa said the ICN must protect professional nurses. The Netherlands' amendment [definition of the nurse] it said, "is disastrous."

New Zealand recognized the need for a strong ICN and wanted more specific functions.

The recommendations of the ICN special committee, were accepted in part, but the committee's belief that "ICN's primary purpose should be to improve health" was rejected.

A statement: "The purpose of ICN is to promote the health of the people of the world through improvement of all aspects of nursing," was passed by majority vote but lost when a two-thirds vote was required to amend the constitution. The original statement that the purpose of ICN is "to provide a medium through which national associations may share their common interests," was retained.

The special committee's report saw strong national nurses' associations as the first requirement, both for a stronger ICN and for accomplishing ICN's primary purpose of improving health. The autonomy of national associations was accepted by the CNR and imple-AUGUST 1973



Jean Pipher, standing, president of the Saskatchewan Registered Nurses' Association 1971-73, participated in a CNA panel presented at a special interest session.

mented in a number of changes in the constitution and regulations.

National representatives accepted a description of the ICN that incorporates the United Nations principles of human rights. (The CNR endorsed the UN Declaration of Human Rights at the Dublin meeting in 1971 and called on all member associations to take steps to support and implement the UN declaration.)

The special committee proposed the following objectives of ICN:

- to improve the standards of nursing and the competence of nurses;
- to promote the development of strong national nurses' associations;
- to serve as the authoritative voice for nurses and nursing internationally;
- to improve the status of nurses.

The first and last objectives were amended by inserting the words "to assist the national associations" before the statement.

Because the votes on the amendments to the constitution and regulations were carried by a simple majority, revoting on the first part of Monday's business, was necessary when members of the CNR requested that each amendment be accepted by a two-thirds vote.

Only the title and description, purpose, and objectives of ICN had been completed in the second round of voting at the end of the Monday sessions.

At the beginning of Tuesday's session, it was moved by the UK and seconded by the USA that the CNR confine further consideration of the amend-

ments to the ICN constitution and regulations, as proposed by the special committee and, in some instances, amended by the board of directors, to articles dealing with the functions of the ICN, the definition of the nurse, member associations, ICN areas, and the board of directors. It was moved by the USA and seconded by the UK that articles dealing with nominations and elections also be discussed and that consideration of the remaining amendments be deferred until the CNR meeting in 1975.

It was moved by the UK and seconded by the USA that the functions of ICN as proposed by the special committee and as amended by the board of directors not be accepted, that the CNR resolve that the functions set out in the existing constitution be reaffirmed, and that the board of directors be requested to interpret these functions in accord with the purpose and objectives of the ICN as approved at this meeting of the CNR. The motion carried.

#### **Definition of nurse**

An important change in the ICN constitution was a new definition that deletes the proviso that a nurse is the person authorized to supply "the most responsible service of a nursing nature." The definition, proposed by the Netherlands and accepted by the CNR, is: "a person who has completed a program of basic nursing education and is qualified and authorized in her/his country to provide responsible and competent professional service for promotion of health, prevention of illness, care of

the sick, and rehabilitation. Basic nursing education is a planned educational program which provides a broad and sound foundation for the effective practice of professional nursing and a basis for postbasic education."

In the preamble to the resolution, the Netherlands made it clear that the second-level nurse should be afforded all the privileges of ICN membership. There was almost no discussion of the issue that had been raised and rejected strongly at the 1969 congress in Montreal. (Report, August 1969, pages 31-2).

Other changes made in the regulations make possible wider membership in ICN. The former membership criteria required a member association to be composed exclusively of nurses, then defined in the ICN constitution as registered nurses.

CNR adopted a new criterion for membership: "Within a country, one national nurses' association or federation of nurses or, where neither of these exists, a separate nurses' section or chapter of a national association composed of other health workers may become a member association of ICN," provided that, if the association is a section of another health workers' organization, the section has its own separate regulations that are not in conflict with the human rights principles, or with the purpose and objectives of ICN.

The special committee recommendation that voting on matters affecting ICN be limited to nurses who meet the ICN definition of nurse was amended to provide that the selection of the national representative, who must be a nurse who meets the ICN definition of a nurse, be made by the member association.



The CNR also accepted an amendment, proposed by the ICN board of directors, that the member selected to be the national representative to the CNR may or may not be the president of the member association.

ICN's board of directors explained this gives the right of selecting the national representative to the voting body of the member association, whether or not all members of the voting body meet the ICN definition of nurse. The directors pointed out the safeguard that if the member association president is not a nurse meeting the ICN definition, the national representative will be. However, the directors' proposed defi-

nition of a nurse did not include the second-level nurse.

The ICN board of directors provided for participation by national association members, other than registered nurses, by allowing them to take part in all ICN matters, except being a national representative, a board member, or a committee member.

By accepting the wider provisions suggested by the board of directors and amending the definition of "nurse," the CNR provided for a wide variety of nursing personnel to become active in ICN. The CNR approved the special committee recommendation that each national nurses' association retain the



right to define its own membership at the national level.

#### **ICN** areas

A proposal that one director be elected from each of seven ICN areas was accepted. The areas are: Africa, Eastern Mediterranean, Europe, North America (Canada and the United States), South and Central America, South East Asia, and Western Pacific. Four additional directors are to be elected as members-at-large. The number of ICN directors, 11, is unchanged; all must meet the ICN definition of nurse.

A proposal by the Netherlands that

ICN should have a formal relationship with regions that have a regional office, a regional president, and regional regular meetings, and that ICN should officially stimulate regions to develop and establish formal relationships as soon as possible was adopted by the CNR.

An amendment, proposed by the special committee, to have the committee on nominations elected by the CNR was defeated.

The standing committee on ICN membership was discontinued by the CNR. Its functions were given to the board of directors, who will make recommendations to CNR on admission

or expulsion of member associations.

The special committee proposed amendments to the regulations to make the board of directors a voting part of the CNR. The board of directors spoke against this, saying it would change the policy of one vote for one country. The proposed amendment was defeated.

During discussion of whether or not ICN directors should be voting members of the CNR, Norway said the board of directors is important and should take an active part in discussion. It said the leadership of those elected to the board of directors should have a part in the highest body, the CNR.

#### **Nursing students**

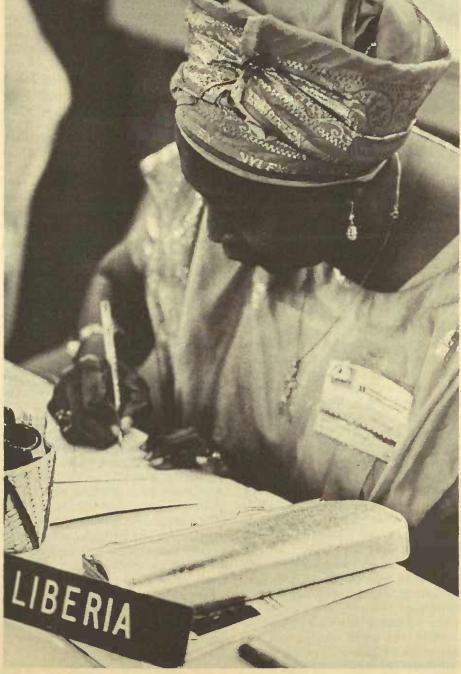
There was loud applause from sections of the audience, some identifiable as students, when the CNR approved a Netherlands motion that the ICN board of directors refer to the professional services committee a suggestion that an international assembly of student nurses meet at the same time as the CNR, with the privilege of sending recommendations to the CNR.

#### **ICN** fees

The ICN board of directors in March 1972 decided to recommend to the CNR that per capita dues be increased from Swiss francs 1.60 to Sw.fr.2.50. At the current rate of exchange, this represents an increase from U.S. \$0.52 to U.S. \$0.80.

The last dues increase was voted in 1961 and went into effect in 1962; it changed the per capita dues from U.S. \$0.185 to U.S. \$0.37 at the rate of exchange at that time. The cost of living in Switzerland, where ICN headquarters are, rose by 56.6 percent between January 1962 and December 1972.





**AUGUST 1973** 

Carol Dworkin, center, at desk, interviewed a delegation of nurses from Cuba for the daily bulletin of the congress. Ms. Dworkin, a member of The Canadian Nurse staff, was seconded to ICN for the congress.

ICN fixed costs increased rapidly during the past 11 years, partly due to the increase in ICN membership from 45 to 74 member associations and the costs of providing service to them.

A background document prepared for the CNR stated: "If the proposed dues increase is not accepted, ICN activities from 1974 onwards will have to be considerably reduced."

Joyce Rodmell, Australia, said in presenting the board's proposal for increased dues: "If we cut the budget further, ICN will not have what it needs to work with. The two biggest budget items are staff and the cost of ICN headquarters." She added that if staff is further reduced, services will be reduced. Three staff positions were left vacant in 1973 to assist with budget cuts.

Many national representatives spoke against the increase. Sierra Leone said that although they were in sympathy with the ICN, they were involved in improving their own association and were unable to support an increase in dues. Chile said their membership was low and developing countries could not pay increased dues.

Kenya said that although it would strain their association, Kenya would support an increase to Sw. fr. 2.0. The motion to amend the increase to Sw.fr. 2.0. (U.S. \$0.64 at present rate of exchange) was defeated.

The discussion returned to the original motion to increase per capita dues to Sw.fr.2.50. The Norwegian representative said she had seen the great importance of the ICN, that the ICN was needed to assist national associations, and without more money it was impossible for the organization to cope with the tasks given it.

The UK representative said that if ICN followed its suggestions to curtail functions to those, essential to the profession, that can only be carried out at international level, there would be no need to increase dues. She further said that if dues were increased, "the UK would examine closely on a cost-benefit ratio the continuance of membership in ICN."

South Africa said it was unjustifiable to raise dues in a period of financial instability; it would effect the expan-



sion of services in the national nursing association.

Many national representatives were on the chairman's list to speak to the issue when it was moved by UK and seconded by USA that debate on the fee increase be closed. Closure carried by the necessary two-thirds majority; the motion to raise ICN fees was defeated.

The UK proposals for curtailment of ICN functions were never moved or voted upon. Among the sections of the constitution and regulations deferred until 1975 was Article VII, dealing with dues; in it is a proposal that member associations pay full dues for all nurse members who meet the ICN definition of nurse, and 50 percent of full dues for all other members.

#### Code for nurses

Among recommendations of the professional services committee accepted by the CNR was a revision of the ICN Code of Ethics. The new document is titled "Code for Nurses — Ethical Concepts Applied to Nursing." It is printed on page (9). Two amendments were approved: one added the creation of a spiritual environment, making the nurse's responsibility "fivefold" as stated in the preamble; the other added a fourth paragraph to the section on "Nurses and Practice."

#### Developing role

A statement on the developing role of the nurse was adopted by the CNR, as proposed by the professional services committee.

The statement is: "In the light of scientific and social change and the goals of social and health policy to extend health services to the total popu-

lation, nursing and other health professions are faced with the need to adapt and expand their roles.

"In planning to meet health needs, it is imperative that nurses and physicians collaborate to promote the development and optimum utilization of both professions. A variety of practices may evolve in different settings, including the creation of new categories of health workers.

"Although this may require nurses to delegate some of their traditional activities and undertake new responsibilities, the core of their practice and their title should remain distinctly nursing, and education programs should be available to prepare them for their expanding role in various areas of nursing practice."

#### Smoking, career ladder

The CNR endorsed pertinent portions of the World Health Organization statements on the limitation of smoking. The acceptance of the policy had little apparent effect on the congress; nurses continued to smoke, although those on the platform did not.

The CNR adopted another recommendation from the professional services committee: that ICN take a lead in further examining the subject of a career ladder in nursing and prepare a statement on nursing education that permits mobility and is in keeping with desirable standards of education and practice.

The committee said one of the problems facing educational systems throughout the world is that of providing more creative and less restrictive approaches to career mobility.

The increasing demand for health

22 THE CANADIAN NURSE



service, as well as people's changing career goals, require an educational system for nursing that encourages continued education and interdisciplinary contacts, the committee said. Ingrid Hämelin, Finland, was chairman of the committee during 1969-73; Laura

W. Barr, Ontario, was a member.

Merren Tardivelle, editor of the ICN's International Nursing Review, reported that two issues (January/February and March/April) had been published to date. ICN member associations were asked to participate in implementing the new style of the Review by appointing a member of the INR participating editorial board.

Ms. Tardivelle said it was with deep regret that it was decided to publish the *Review* in English only; the financial implication of publishing in several languages was the deciding factor. However, she said ways and means of printing some full-length articles in French and Spanish were being explored.

During discussion of Ms. Tardivelle's report, Alice Girard, second vice-president of ICN for 1969-73, said she was pleading for the *Review* so that it "may be truly international. We have changed the content and changed the format, but we cannot say it is fully international when there are only 3,500 subscribers. The *Review* can only be published in other languages when there are more subscribers. "Will you help us to help you get your message across?" Dr. Girard asked.

#### **Worldwide Color**

At no time is the worldwide character of the International Council of Nurses AUGUST 1973

displayed with such color and pageantry as in the opening and closing ceremonies of a quadrennial congress.

On Sunday evening May 13, Canada led the parade of national nurses' associations in the opening ceremony. With five male student nurses forming an honor guard for Canada's flag, CNA's president Marguerite Schumacher and CNA's executive director Helen Mussallem entered the main floor of the Sports Palace before an audience of about 6,000 nurses.

The President of Mexico was represented by his wife and by the Minister of Public Health, who delivered the presidential address of welcome.

In her welcome, Sara Alicia Ponce de León, president of the 400-member Mexican nurses' association, said: "We know that if we want to make our contribution, there can be no place for isolation, or for a feeling of solitude within each one of us; the only justified solitude is the creative one, later translated into action shared with others. We must have enough strength to exist individually and at the same time to be part of a united whole. This feeling of solidarity must live and bind us to one another if we want to attain constructive goals."

Margrethe Kruse, ICN president, said at the opening: "If we agree that nursing is a work of humanity, we have accepted responsibility for defending the human rights of man. This responsibility leads us far beyond the narrow limitations of the concept of nursing per se. It means that nurses are concerned with all affairs that affect man.

"We live in a rough world... for from 196 millions and millions of our fellowmen: of office.

The comments of the Cuban nurses were eagerly recorded by media representatives from various countries, during Ms. Dworkin's interview.

a world of wars, injustice, exploitation, illness and suffering; a world where the gap between the rich and the poor countries is widening; a world of overpopulation and of undernourishment... and of disrespect for man as a human being.

"But nursing is nonpolitical and all these aspects of life are political or influenced by politics. It seems like a conflict but it is not. It is the human aspect of politics that is of concern to nurses. Therefore, nursing can never be nonpolitical. It is rather multipolitical, guided in its political\_interest by its concern for man."

The closing ceremony on Friday night had several highlights: the admission into membership of six new nursing associations, the transfer of the presidential chain from Ms. Kruse to Dorothy Cornelius, and the farewells.

Marguerite Schumacher represented Canada in sponsoring the nurses' association of Zaire, a Francophone, African country. Zaire, the last country to be admitted to ICN, brought the ICN member associations to 80.



Margrethe Kruse, president of ICN from 1969 to 1973, wearing the chain of office





Esther Z. de Echeverría, left, wife of the president of Mexico, with Sara Alicia Ponce de León, president of the Mexican Nurses' Association, at the opening ceremonies of the congress.

In addition to carrying Canada's vote in the Council of National Representatives, CNA president Marguerite Schumacher was a member of the resolutions committee during the congress.

Dorothy Cornelius, right, ICN president for the coming quadrennial, talked with reporters after her election was announced.

It is the custom of the outgoing president to give a watchword for ICN during the coming quadrennium. Margrethe Kruse, whose watchword for 1973-77 is "flexibility," said: "It is a strategic attitude of work that can be of paramount importance in the development of nursing. It is of equal concern to the individual nurse and to her associations, national and international. It can be a guide in adjusting and coordinating functions and activities according to needs, demands, facilities, and possibilities.

"But it is a tool that is difficult to handle. It requires intelligence, a clear identity, professional responsibility and maturity, knowledge and wisdom and, more than that, it requires a well-

defined goal."

Dorothy Cornelius of the USA., president of the ICN for 1973-77, said that among her goals for the next four years are increased membership; ways to elicit and use increased input from individual members of national associations; and strengthened communications between the ICN board of directors and member associations.

**Plenary Sessions** 

Wednesday, Thursday, and Friday mornings were devoted to papers and panel discussions on the theme of the 15th congress: Nurses and Nursing.

"Health care must be for people, not for patients," Jeannette Folta, USA, said in her paper on humanization of services and the use of modern technology in health care. She spoke Wednesday morning in the first plenary session.

According to Dr. Folta, the popular view that decries technology is "roman-



tic nonsense." "Three-fourths of the human population," she pointed out, "live in isolated, undeveloped, agrarian society, that romantic place of simple relationships, few changes, and virtually no technology. These three-fourths of the human population live under extreme deprivation, tremendously difficult survival conditions, a short life-span, high illness and mortality. The return to nature is full of cruelty and certainly not humanitarianism."

Nurses have cried that freedom from technological tasks will increase their time at the bedside. "Yet," concluded Dr. Folta, "we have absolutely no evidence to verify that increased efficiency and decreased attention to technology translates into more direct and humanistic care."

Catharina Verbeek, Netherlands, commenting on Dr. Folta's paper, said: "We start nursing education in a place where the highest requirements are asked of hygiene, sterility, technical skill, speed, and routine. We start in a situation where there is little or no place for inventiveness, creativeness, and our own decisions. There are small responsibilities resulting in little satisfactions."

Catherine M. Hall, UK, said nurses must control their own profession through a strong national nurses' association. Replying to the question: who controls the nursing profession?, Ms. Hall suggested that most professions are subject to external controls to a greater or lesser degree.

The critical issue today, said Ms. Hall, "is the extent to which a profession can influence where it cannot control." A strong professional association is the means by which a profession is enabled to influence where it cannot directly control, she said.

"In order to fulfill its dual commitment to advance professional service and to promote the welfare and wellbeing of its members, the association must be seen to be concerned with both the interests of society and with the interests of its own professional practitioners," Ms. Hall said.

Sheila Iu, Hong Kong, who summarized the discussion by a panel of

Two nursing students were on the program at a plenary session. Roy Heine Olsen is a student nurse-member of the board of directors of the Norwegian Nurses' Association; Helen Fleminster is a student at the school of nursing, John F. Kennedy Medical Center, Monrovia, Liberia.

seven nurses, said the most important control of the association lies in the hands of nurses themselves. She said the association can help members to help themselves, and this must be done in ordinary as well as in critical times.

#### **Belief into practice**

The first topic in the plenary session on Thursday was "translating a nursing belief into nursing practice." Rebecca Bergman, Israel, said: "Translating a belief into practice has mostly been undertaken by leaders. Nursing could be more effective and satisfying if translating beliefs into practice became an integral part of all nursing practice." The majority of nurses can acquire the intellectual and interpersonal knowledge and skills needed to formulate and implement beliefs, Dr. Bergman said.

Elisabeth Stussi, France, spoke about

the health team. She said: "To focus the team on health would bring into question all our nursing care focused on illness. We have made the sickness of people our field. We should question the negative aspects of this.

"It is classical to recognize the doctor as the head of the health team. Leadership of the team should come from different members, including the person being helped. This requires adaptation.

"It is not sufficient to be a health team but it is necessary to be a healthy team," Ms. Stussi said.

CNA's president, Marguerite Schumacher, presented a paper on continuing education for nurses.

"Continuing education for the nurse should be measured not only in terms of her role as a nurse but also in terms of needs for her own 'essential living,'" Ms. Schumacher said. If continuing





Three Mexican nursing students rest their feet and look at manufacturers' samples between sessions. Nursing students acted as couriers on the buses that transported nurses to the congress site daily,

education is limited to organized learning experience, it fails to recognize the significance of self-directed learning.

"Continuing education for all health professions is imperative," concluded Ms. Schumacher. "Continuing education is an attitude. Learning requires hard work. If nursing is to continue to develop as a profession, committed learners are essential."

In the panel discussion that followed Ms. Schumacher's presentation, Elouise Duncan, Liberia, emphasized the importance of motivating people with money, facilities, and know-how to provide programs of continuing education. The value of courses is not purely for nursing per se; it is an opportunity for the nurse to broaden herself, to choose subjects of study. The goal of continuing education, Ms. Duncan said, is improvement in nursing practice and in the nurse.

Vilma de Carvalho, Brazil, thought continuing education should be patient-centered. The student should learn how to be a good nurse and a good neighbor in society.

#### Goals and values

Sara Alicia Ponce de León, Mexico, discussed goals and values for the nursing profession at Friday morning's plenary session. "Nursing, precisely because it is predominantly a woman's profession, is bound to be affected by nurses' ideas of 'womanliness,' by the positive or negative value they attribute to it, by their acceptance of the feminine condition, and by the kind and quality of their relationship with the opposite sex," Ms. Ponce de León said.

"Some nurses are unable to liberate themselves from their...biological



Representatives of the Japanese Nursing Association put forth the merits of their country as the site of the 1977 congress.

function and tend to be indiscriminately 'motherly' to patients; they even feel they are 'very good nurses' if they do everything for the patient and treat him as a baby, instead of encouraging his independence. This role then projects itself onto other members of the health team."

It is worth trying to change attitudes, Ms. Ponce de León believes, "because nurses who do change secure a new dignity, respect, and freedom in their relation to people around them, and this improves the quality of their work."

During the panel discussion following this paper, Ingeborg Mauksch, USA, said there have been five recent value changes all over the world in relation to health: health care has become a right; it is a matter of prevention; health care is centered in the community, rather than in the hospital; the consumer is participating in decision-making on health care; and health care costs are born by the total society through governmental support.

Fumie Kobayashi, Japan, said the practice of nursing has not changed. The values and goals are expressed in beautiful terms but there is a great gap between what is expressed in words and practice.

Mira Pridgar, Yugoslavia, said nurses easily forget the personal component; we seem afraid to be old-fashioned and offer a considerate and kind approach.

Colton V. Bennett, Barbados, believes that nursing schools should be attached to hospitals because students need to be in touch with patients. He also said nurses need to examine the rivalry between the sexes in the profession. "Men fail to identify enough with females in the profession and with their own association. Males who are not interested in nursing should get out and look for another job," he said.

Vera Maillart, USA and Italy, who summarized the congress, quoted Jean Piaget who said that the principal goal of education is to create men capable of doing new things.

#### **Special Interest Sessions**

Special interest sessions were offered on Wednesday and Thursday afternoons, in the three Congress languages. There were 27 panels in English, 22 in Spanish, and 9 in French.

Besides the four panels provided by Canadian nurses, two in French and two in English (News, April 1973, page 9), Wendy Gerhard, Ontario, chaired an international panel on "fnternational Cooperation in Nursing Education"; Joan Macdonald, Ontario, was a member of an international panel on "The Role of the Nurse in Social Change"; Lyle Creelman, B.C., chaired an international panel on "Partners for the Health Team: Patients, Families, Students"; and Dr. Josephine Flaherty, Ontario, took part in a French panel on "Qui régit la profession d'infirmière?"

The two all-Canadian sessions in English were held simultaneously Wednesday afternoon. In the group moderated by Dr. Helen K. Mussallem, the topic was new sensitivity in the process of communication. Jean Pipher, Sas-

katchewan, said teachers and students have learned that "the teacher is not allpowerful, the student is not emptyheaded, and content is not holy."

Sensitivities that continue to be new in application are that a person does the best he can at all times; persons have a right to feel anxiety, love, grief, joy; and they have a responsibility to understand feelings and grow in them, Ms. Pipher said.

Margaret Neylan, BC, said most professions are "going it alone, or one profession is dominant and helping the others." "Competence," she said, "is the currency of interprofessional exchange."

The professions lack a neutral arena in which to talk with each other, rather than for or about each other. Ms. Neylan said. There are some obvious pitfalls in patterns that nurses have in interprofessional communication. She identified: superficial acquiescence in face-to-face contact and a hostile aftermath among their nursing colleagues; a generalized aggression, resulting from underconfidence; and an unrealistic expectation of the rate of change in other professions after nurses have changed.

To overcome difficulties in interprofessional communication, she suggested nurses maintain continuity of practice; assume leadership in appropriate ways; become skilled in debate without losing their "cool"; do homework so they go to interprofessional meetings with facts and a position based on those facts; and identify major health problems.

Josephine Flaherty, Ontario, spoke of sensitivity in communication between nurse and nurse. "Nursing is not comfortable with words and not precise in the use of words. We have a nursing jargon but we cannot explain to each other the meaning of the words. Nursing is used to the silent language of service," Dr. Flaherty said.

"How often do we look at the stresses we put on those nurses who have responsibility for groups of nurses?" We should look at the situations in which we work and at the stresses we place on each other, and seek a chance to talk about professional problems, she said.

#### Students' View

Three students in the third year of bacealaureate programs in nursing sent *The Canadian Nurse* their comments on the ICN Congress. The following is the view of Laurel Duke, U of Ottawa;



Jo Brazel, Mount St. Vincent U, Halifax; and Janet Morton, Dalhousic U., Halifax.

"Any student who has an opportunity to attend an ICN conference should not miss it. The chance to talk with the nursing leaders of many countries was one of the things we found beneficial. Papers, presented by authorities in many areas of nursing, stimulated us to think about and focus on aspects of nursing that we were only slightly aware of.

"However, the congress was not all perfection, nor could this be expected. Many of us hoped to hear about new aspects of concern for nursing. Instead, we heard about "Who controls the profession?," "The Health Team Concept," and so forth. We realize these are relevant issues, but surely something concrete could be done about them so nursing could expand into broader

aspects of health care. Some students, however, were satisfied with the topics presented and felt these met their needs.

"Most students were disappointed that nothing has been organized for us by the ICN organizing committee or by the Mexican nursing students. Therefore, a few Canadian students organized a student meeting. Our plans were enthusiastically welcomed by Ms. Kruse, ICN president.

"Despite a few technical difficulties, a small but enthusiastic group of students representing 10 countries met Friday morning, May 18. We discussed student nurses' associations and nursing education in our countries. We were dismayed to learn students in some countries do not have even a student's council in the hospital or university.

"All representatives of organized nursing student bodies agreed we must help other students set up their own organization, whether on an individual school or national basis. Many Canadian students expressed concern that in Canada we do not have a body representing nursing students from all types of programs across the country. It was generally felt that the students at the ICN congress this year are the ones who must lay the groundwork for a student assembly at the next ICN congress in Tokyo in 1977.

"Although we had good times and bad at the congress, we are all extremely grateful for having had the opportunity to attend the congress as students."

Photos by W. VanKirk Buchanan, courtesy of *American Journal of Nursing*.

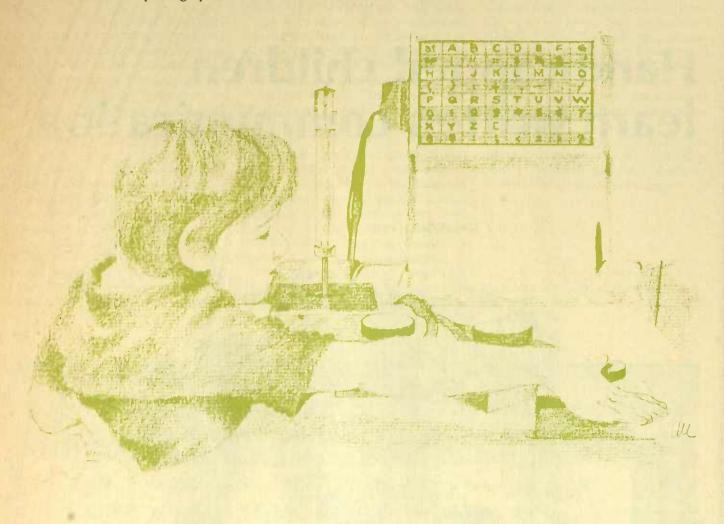


# Handicapped children learn written communication

Earl Maser



Electronics has brought the written word within reach of those who cannot communicate and is opening up a whole new world for them.



At first glance, a large schoolroom in Ottawa gives the impression of being a bright, warm playroom. At the far end, children's toys and games — puzzles, blocks, hobby horses, tricycles, toy cars, a shuffleboard — lie scattered on table tops and the floor. Nearby are a workbench with carpentry tools, a blackboard, and a cupboard on which rests a large colorful plastic ball. Beside the cupboard stand low parallel bars and, a few feet away, a small set of stairs with handrails, flanked by mats.

The left side of the room is divided into three work areas. The area closest to the entrance contains desks and chairs for adults. The one at the back is just a small cubicle with a work desk, a few small chairs and table, the latter

dominated by a large, tilted mirror. A colorful partition decorated with finger paintings of flowers in orange, yellow, and purple separates this area from the neighboring cubicle, which is furnished with a child's desk, a table, and a battery of machines.

This room is officially known as the physiotherapy area of the Ottawa Crippled Children's Treatment Centre.

The children's games are the tools of the occupational therapist; the parallel bars and stairs assist the physiotherapist; the tilted mirror is the speech therapist's, and the long desks are for report writing, evaluations, and putting hopes on paper.

The small middle cubicle, with its table and desk flanked by machines, is

for learning to communicate. In these few square feet of space, a dedicated teacher, using equipment designed and built by two scientists from the National Research Council of Canada (NRC), is making history in the treatment of speechless crippled children. Here, amid the complex electronic equipment, some crippled children have for the first time in their lives been able to communicate by using words written on an electronic typewriter.

The teacher is Wendy Eastman, a 22-year-old graduate of Ottawa Teachers' College and graduate technician in biomedical engineering from Algonquin College in Ottawa. She instructs crippled children throughout the school year and directs a day camp for them

**AUGUST 1973** 

during the summer holidays. For two years now she has worked around the calendar with handicapped children.

### Machines devised

The machines are the brainchild of O.Z. Roy and J.R. Charbonneau, researchers in the instruments section of NRC's Radio and Electrical Engineering Division who, in 1963, developed their first communication system for the handicapped (COMHANDI). For those unable to speak or write, COM-HANDI serves as a means of communication with words.

In concept, the NRC communication system for handicapped people is designed to give quick, casy access, with minimum stress and maximum use of the child's abilities, to a wide range of letters and symbols. This is accomplished through devices specially designed to encourage maximum participation from the child activating various controls. One of these controls scans a display board, first in the horizontal direction and then, when reactivated, vertically to arrive at the desired letter or symbol. This chosen symbol is then recorded graphically by means of an electronic typewriter. In this way, words and numbers can be written fairly rapidly, and people handicapped with voice, arm, or coordination problems can now communicate.

Most of the crippled children took to the first COMHANDI system right away. Initially, it had four major components: a control system containing a small display board with room for 64 letters and symbols, an electronic typewriter, a system for converting code signals from the control system to the typewriter, and a five-by-eight-inch box for hand controls. Over this box was a bar for activating the scanning control. In addition, buttons on the box controlled the "type," "space," and "carriage reset" commands.

A few weeks after tests began, the hand-control box was replaced by a set of paddles, brightly colored for easy identification. Except for some mechanical switches, the system was entirely transistorized.

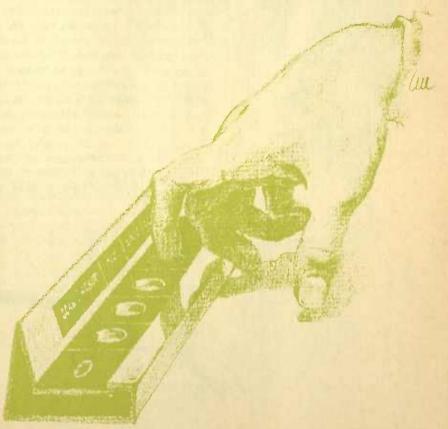
The thrill of working this machine completely by themselves and seeing quick results had the children looking forward eagerly to each session. Assisted by their teacher, they progressed rapidly toward mastering the machine.

But there were problems, and despite their obvious pleasure with the machine, the children, through Ms. Eastman, made these problems known. The NRC team began work on designing a new model that would be modified according to the children's own suggestions and reactions and that would be more easily adaptable to the individual needs of each child. For example, the display board was increased in size and the control system was changed so children did not have to scan the whole display board each time they needed a symbol or letter.

The children wanted a faster pace for scanning, so the system was modified to scan at from one letter per second to four per second, as controlled by the teacher. As an additional aid and a means of reinforcement for learning, the children hear a high-toned beep for each address as the scan procceds horizontally, and a lower tone for vertical scan.

# Specially for Jeannie

Neither the new paddles nor the bar of the original hand-control box were satisfactory for Jeannie. She was unable to produce sufficient hand pressure to activate the controls, even though the NCR team used the most delicate switches and levers, requiring but a few grams of pressure to operate. With mechanical control ruled out, the NRC researchers developed for Jeannie a special optical system using lamps and photocells in a series of holes.



She operates the system by placing her finger in the appropriate slots between lamp and photocell. The interruption in the flow of light activates the controls. The same principle enabling a shopper to open the front door of supermarket automatically — the photoelectric effect — also permits Jeannie to communicate with words.

This COMHANDI model was in operation during the 1971-72 school year with good results; with it the children were able to halve the time needed to write with the original model.

The second version was further modified and a third model was ready soon after the start of the 1972-73 school year.

In addition to improving the circuitry and putting all equipment into a single unit, the NRC team developed a removable display board with letters in alphabetical order. With this display board the children not only had access to the letters, but were also able to "control their environment." For example, they could turn on and off lights and appliances, such as radios and television sets.

In November 1972, another feature was added to give still easier access to the desired letter or symbol on the display board: a "joystick" in the form of a hinged, vertical rod that controls the scan on the display board. This feature enables the child to take the shortest path to the letter or symbol he wants,

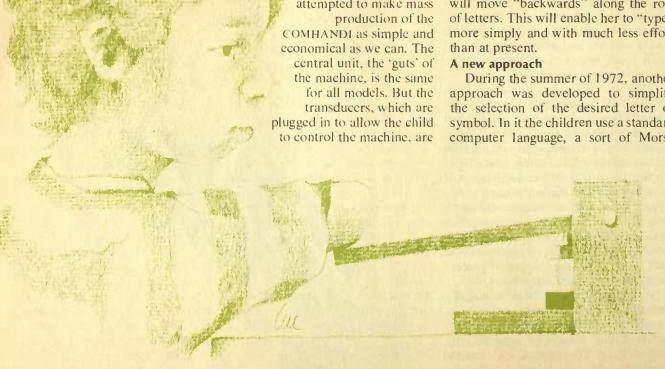
since the scan moves in the same direction as the joystick itself (up-down, right-left, or diagonally). "We have aimed at involving the child as much as possible in working the machines," says Mr. Roy. "At the same time we have attempted to make mass production of the COMHANDI as simple and economical as we can. The central unit, the 'guts' of the machine, is the same for all models. But the transducers, which are plugged in to allow the child to control the machine, are

designed to exploit the child's abilities as much as possible and to encourage his full participation. The machine itself can be produced on an assembly line, but time and careful study are needed in developing the transducer best suited to the child. Jeannie's optical controls, along with the paddles and joystick, are just three examples of what can be developed for these children.'

Canadian Patents and Development Limited, a subsidiary of NRC responsible for patenting and licensing government inventions, has been attempting to find a company to manufacture the COMHANDI.

A new "optical joystick" is now being developed for Jeannie and will soon be integrated into this system. It involves a seven-hole plate with four of the holes forming a diamond. Each hole has the same lamp and photocell as the optical board that Jeannie now uses. When she places a finger in the uppermost of the four holes, the light will scan up the columns of letters and symbols on the display board; if the hole on the left is chosen, the scan will move "backwards" along the row of letters. This will enable her to "type" more simply and with much less effort than at present.

During the summer of 1972, another approach was developed to simplify the selection of the desired letter or symbol. In it the children use a standard computer language, a sort of Morse



Code for letters and symbols. Each symbol is made up of at most five dots; scanning can thus be limited to a single row with six frames, the last for "type," the other five to be selected or not depending on the "code" for letter.

The computer code follows a logical pattern and has proved easy to learn. It has several advantages, one being that a child does not have to hunt for a letter. Knowing the code for the letter he wants, he just has to turn on the appropriate frames on the display board as the scan comes over them. Should he not activate the last frame to type this letter, the scan is canceled and starts over again.

Another advantage is that, in addition to the usual typewritten text, the electronic typewriter can produce a perforated tape in the computer language code. By running this tape through the typewriter again, the child can easily make copies of the text. Also, errorfree drafts can be produced, since the typewriter can be made to skip lines with errors.

The COMHANDI system gives handicapped people a tool for turning out flawless written work; this could be an important step in ultimately making them more self-sufficient and less dependent on society. In fact, Jim, a limbless child and enthusiastic user of this system, has had such success with it that he is thinking of using it for his future career!

"At first, there were problems with the COMHANDI system, mainly technical, and in getting the children accustomed to using it," says Ms. Eastman. "But the last two models have proved much more functional, particularly with the added controls for speed.

"The children have come a long way from the point of view of speed, accuracy, and getting what they want down on paper. Very few mechanical difficulties exist now with the equipment and, considering what COMHANDI does for the children, we hope it will soon be one of the tools in the classroom, for it fits in well with regular public school work in spelling and mathematics.

"The machines seem to give the children increased incentive, and a desire to do their best is immediately evident. For these children, as for every child, determination to work and succeed is of prime importance. Don't forget that they are children first and handicapped children second. The more their studies and other activities can be made appealing to them, the better they'll do.

"For their teachers, COMHANDI provides a dependable way of seeing if the children have really understood and assimilated their lessons. They now spell, do mathematical problems, answer questions on texts, just as other pupils do," Ms. Eastman says. "Often we see them smiling as they work at the machine. COMHANDI enables them to see that they are making real progress in their learning.'

What does the future hold? A new Ottawa Crippled Children's Treatment Centre is being built just a stone's throw from the new Children's Hospital of Eastern Ontario in Ottawa. The Centre hopes to move into its new quarters at the start of the 1973-74 school year. L.H. Murphy, administrator of the Treatment Centre, looks forward to its growth with these words: "The Centre administration is hoping to welcome more staff and even greater participation from NRC, with the good results that this could bring."

Earl Maser is a staff writer at NRC.

Permission has been kindly given by the Public Information Branch of the National Research Council to adapt this material from Science Dimension, vol. 2, no. 2, April 1973, pp.8-13.

# Problem-oriented charting — a nursing viewpoint

When notes are related to the patient's problems, charting has more meaning for nurses caring for that patient.

# Frances Howard and Penelope I. Jessop

The nurse's role in patient record keeping has been a critical and often disturbing element of nursing practice. Disparaging comment has been made on the content and quality of nurses' notes. To be sure, "a good day" and "slept well" conveys little to the reader concerning the patient's condition and progress, and these "notes" have been equally distressing to nurses as to other health professionals.

A further annoyance has been the matter of discarding nurses' notes on the patient's discharge record. Nurses have meaningful messages to relay to other health professionals and, if one had the inclination to read a sample of nurses' notes, these messages would be evident.

On the other side of the coin, when the nurse is reminded that one of her functions is to coordinate the medical care plan with the nursing care plan, she responds, "What medical care plan?" It is difficult to sift out the relevant medical data from all the various notes recorded by the doctor or doctors on the many pieces of paper randomly distributed throughout the chart.

It is not surprising, therefore, that the initiation of problem-oriented charting at the Kingston General Hospital (KGH) has been received positively by most nursing staff. True, there are problems. However, acceptance of change allows for collaborative effort in their solution.

### What is problem-oriented charting?

Treatment of the patient as an individual with singular behavioral characteristics has long been recognized and this philosophy of patient care is best achieved through a problem-solving approach. Needed are two basic elements — accurate and relevant information and a continuous channel of communication. The problem-oriented chart is the agent by which the philosophy is implemented.

The chart components (diagram 1) clearly designate the required stages in problem-solving and how patient care and progress should be recorded. It is analagous to the established approach to the provision of nursing care (the evolvement of a nursing care plan through identification and assessment of nursing care needs). Its further merit lies in the allowance for interrelated contribution by all health professionals involved in the care of the patient.

# How does it work?

First let us examine the word "problem." A problem is any concern of the individual patient requiring further

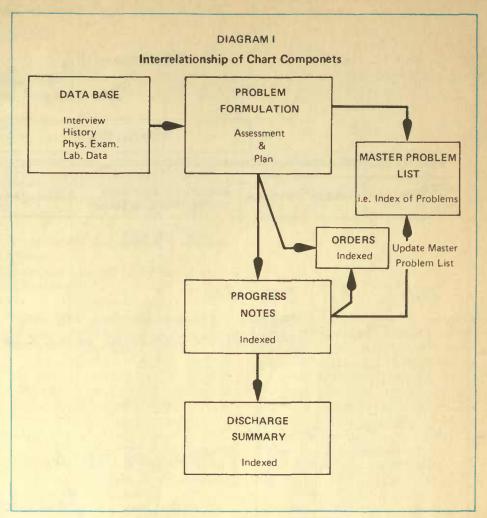
The authors are the director and assistant director of staff education at the Kingston General Hospital, Kingston, Ontario.

attention. It is not necessarily negative or troubling, but health team members must remain aware of it.

Problems are first identified by the patient - something has happened to cause him to seek medical help. The doctor pursues the patient's problems in more depth, and refines and records them on the problem list. Here, each problem is identified by a number and title. This list (diagram 2) becomes an index to the individual patient, indicating the medical foundation for care.

A medical care plan is designed and identified as the management plan. Doctor's orders are written under the number and title of each identified problem. Thus, the medical care plan is clearly apparent, so apparent, in fact, that we not only know what is required in the way of treatment, but why — the medical reason for instituting treatment. The interrelationship of these chart components can be seen on diagram 1. At the same time, the patient's nursing needs have been identified and appropriate action planned, coordinating nursing care with medical care.

What does the nurse contribute to the patient's record? With the introduction of the problem-oriented record, KGH has modified the traditional chart. For example, action taken on



# DIAGRAM II

Problem List					
PROBLEM	NO	DATE (1) ONSET	DATE (2) DOCUMENTED	DATE (3) INACTIVE	
MAUSEA CHEST PAIN -NON-RADIATING MEDIASTINAL	1.2	15/11/72	16/11/72		
ANXIETY ELEVATED B.P.	34	7 July /70	16/11/72.	.ge.C: /11	

- 1. Estimated date of onset of the problem, Give day/month/year.
- 2. The date documentation of the problem begins in the chart,
- 3. The date the problem was resolved—it corresponds to the date in the record the documentation ends.

# DIAGRAM III

**Progress Notes** 

DATE and TIME	PROBLEM NO.	TITLE OF PROBLEM	RECORD OF PROGRESS UNDER THESE HEADINGS	Subjective Objective Assessment Plan T	SIGNATURE
			NOV 1 8 1972		
11	05	#2 - CHEST	PAIN		
		PATIENT	- STATES THIS IS	THE FIRST MORNING HE HAS	HAP NO
		Discom	FORT. RESTING 9		
				June Sawyer, Reg. n	1.
15.	15 #	=2 - CHEST PAIN	4		
				1. RESTING CONFORTBELY	
				June Sawyer , Eg. M.	
	2			June Sawyer, Leg. M.	
180	0 :	Her problem	a seclusive non	- conversant. So not willin	4 40
		take brieff u	rolk to nurse as	- conversant. Is not willing. he had been doing.	<b>8</b>
		V		Edna Black, R.N.	
100	f.	B. 21.22	· 422 0 - P 1		
1920	ne ne	A'S. WIFE	SPOKE I ME S	THING SHE IS VERY CONCERN ST PAIN IF HE UNIGER TAKES	IEN ABOUT
	HE	R HUSBAND'S FE	THE of RECUREING CHE	ST PAIN IF HE UNGERTAKES	ANY
	GRA	DUALLY INCRE.	RE Z THEM BOTH	ABOUT THE WEED FOR	
					Re-
	910	IEN BY ALL	STAFF.	THE HING AND ENCOURAGEMENT	^
				John J. Turner.	M.D.

# **DIAGRAM IV**

Subjective Data — patient's symptomatology

- patient's stated viewpoint

Objective Data — valuable physical findings

— signs you actually observe, hear, etc.

Assessment — a tentative conclusion developed from facts

— keep in mind the original objectives of care. (You may consult other team members in developing

your interpretations. Don't be afraid to offer ideas.)

Plan

— how you can best assist this patient to meet his needs

and solve his problems

— prepared in light of each indexed problem and its

relationship to other problems

prescribed treatment and medications is recorded, as usual, on appropriate record forms, as determined by hospital practice. These record forms, now called flow sheets, have been extended to include the recording of a variety of information on what occurs continuously over time, for example, progression of affect in a psychiatric patient, or a patient's response to medication regime. The nurse continues to contribute to these sections of the chart. making certain the most up-to-date information is documented. The major transition has involved the nurse's contribution to the progress notes.

All who contribute to the patient's care record relevant information on the progress notes. The notes (diagram 3) are numbered and titled according to the problems to which they refer. The date and time of each entry is recorded. Clearly legible documentation is emphasized, and each comment is signed with full name and status. A simple formula — subjective objective assessment plan (S.O.A.P. diagram 4) - provides the guideline for organized documentation. As new problems occur they are recorded by the nurse, or other health professional involved (marked as "temporary" or "new" problems). Once relevancy has been established, these are added to the problem list by the doctor.

# Implementation

As with any change, the system must be understood before physical innovations are made. Certain difficulties can be anticipated and considered in shortand long-term planning. Our major objective was to improve patient care through implementation of the system. This objective and the anticipated difficulties provided the focus of attention throughout the change process.

Preparation of nursing staff for the change was in three phases: 1. explanation of the philosophy and its implications for nursing practice; 2. instruction on chart construction and techniques of charting, with emphasis on the cooperative nature of the progress notes; and 3. evaluation of nursing participation, including follow-up guidance on troublesome points.

Instruction was carried out in group discussions, with individual follow-up at the nursing unit level and on a one-to-one basis during all phases. Audiovisual programs were developed for use as instructional aids.

The system had already been in operation in one medical nursing unit for a year. Therefore, the support and counseling of nursing staff in this unit were valuable in preparing staff for the change. As the system matured, specific areas of concern became evident. It became apparent that frequent exchange between medical staff, nursing personnel, and medical records staff was essential. A committee was established, difficulties were aired, and decisions acceptable to all parties were made. Difficulties encountered on individual nursing units were resolved at the unit level and their resolution shared with other units.

The system has been in effect in all medical nursing units for more than six months. We have found that continued reinforcement is needed to assure all comments recorded in the progress notes are related to a specific problem number and title. Nurses need to be encouraged to contribute to this

cooperative documentation and to exercise their degree of understanding and competence in assertion of definite observations and nursing assessments. The order of the chart must be consistent on all units, with only minor flexibilities of physical form made on wards concerned with special services.

# Relevance for nursing practice

An oft-repeated complaint in medical practice has been the lack of communication between doctors and nurses. All recognize the need to share information and to decide jointly on a course of action; yet they appear to work in isolation. Such, indeed, seems to be the case with all health professionals.

The organized problem-solving approach to patient care, involving all health team members, allows for the development of a complete patient profile. As continuity is provided between the medical and nursing care plans, the importance of the nursing plan for nursing practice has become more obvious to the individual nurse. Comprehensive care plans directed to specific problems and focusing attention on the patient as an individual are more evident.

At KGH the team concept is now not only talked about, it exists. Nurses now feel they are truly members of the health team. They are free to make nursing judgments on patient care and to record these judgments on the common record. Their assessments are now read, and attention is paid to them.

Herein lies the greatest satisfaction to nurses — an opportunity to communicate, to be heard and recognized — and to better understand the care they give their patients.

# names

# RNANS Annual Meeting Gets Off To Lively Start



Josephine Flaherty, center, addressed more than 300 nurses in her keynote speech at the annual meeting of the Registered Nurses' Association of Nova Scotia, held in Halifax June 14 and 15. Dr. Flaherty, dean of the faculty of nursing at the University of Western Ontario, said the nursing profession "has become one of the most active and aware groups of professionals in the country." But she noted: "Nurses have never known more disaffection and disappointment with the quality and quantity of health service which is available today." Enjoying a break with Dr. Flaherty are Halifax branch president Margaret Bayer of Dartmouth, left, and Joan Fox of Kentville, past president of the Registered Nurses' Association of Nova Scotia.

Audrey Thompson of Red Deer was chosen nurse of the year by the Alberta Association of Registered Nurses at its convention in Calgary in May.

Ms. Thompson (Ř.N., Holy Cross School of Nursing, Calgary; B.Sc., U. of Alberta, Edmonton; M.N., U. of Washington, Seattle) has been involved

in all nursing teachin School in Lett associa nursing bridge Hospit ly Me

in all aspects of nursing, including teaching at the Galt School of Nursing in Lethbridge and associate director of nursing at the Lethbridge Municipal Hospital. Currently, Ms. Thompson

is a medical-surgical specialist at the Red Deer General Hospital, where she has devoted much time to developing nursing care plans, conferences, and other hospital activities. She is also vice-president of the AARN.



Marjorie Jackson director of nursing Brandon Genera Hospital, became the twenty-firs honorary membe of the Manitob: Association of Reg istered Nurses at it 1973 annual meet

ing held in Brandon, Manitoba.

Ms. Jackson (R.N., Brandon Genera Hospital School of Nursing; Nursing Admin. Cert., McGill University), who has called Manitoba home most of he life, nursed in Peekskill, New York, fo two years and was matron at the RCAI Burns and Plastic Surgery Hospital in Sussex, England, during World War II.

An active member of MARN, Ms. Jackson has served on many committees and was 2nd vice-president in 1963-65 and chairman of the accrediting committee, 1970-72. She has been president of the Victorian Order of Nurses in Brandon and of the Brandon Quota Club, and has served on the Western Manitoba Guidance and Counselling Board.

Mary Irving has been appointed director of nursing service, Hotel Dieu Hospital, Chatham, New Brunswick.

Ms. Irving, who received her basic nursing education at Hotel Dieu Hospital .school of nursing, Chatham, has been associate director of nursing service since January, 1971.

# Alberta Nurse Honored



Madeline Godfrey, left, was named honorary member of the Alberta Association of Registered Nurses at the association's annual convention in Calgary, held May 1 to 4. Ms. Godfrey, who was honored for her efforts on behalf of practitioners in northern Alberta, is shown here with Marguerite Schumacher, president of the Canadian Nurses' Association.



Lynn McClure was elected second vicepresident of the Manitoba Association of Registered Nurses at its annual meeting in Brandon in late May. Ms. McClure (B.N. Mc-Master University,

Hamilton) is nursing coordinator, ambulatory services, Health Sciences

Centre in Winnipeg.

Also elected to the board of directors were three members-at-large: Sister Cecile Gauthier, Edith Giesbrecht, and Audrey McClelland.

Alice R. MacKinnon, Edmonton, is the newly-appointed registrar of the Alberta Association of Registered Nurses.



Ms. MacKinnon (R.N., U. of Alberta Hospital, Edmonton; B.Sc., U. of Alberta; M.N., U. of Washington, Seattle) has had experience in public health nursing in Canada and in the

United States. Positions she has held in Alberta include principal of the School for Nursing Aides in Edmonton; associate director of nursing education at Foothills Hospital school of nursing, Calgary; and assistant professor, school of nursing, University of Alberta.

Grace Johnson has recently retired as consultant in nursing services, Department of Veterans Affairs (DVA), Ottawa.

Ms. Johnson (R.N., Winnipeg General Hospital school of nursing; B.N. (Admin), McGill University, Montreal), on returning to civilian life after service with the Royal Canadian Army Medical Corps during World War II, resumed her association with the Winnipeg General Hospital, where she became director of the Women's Pavilion. She was director of nursing at the McKellar General Hospital in Fort William before her appointment with the DVA.



Registered nurses, our community needs the benefit of your kills and experience. Volunteer

John Ambulance nursing and child care courses.

Contact your Provincial Headquarters, St. John Ambulance.

# **POSEY LAP ROBE**

The Posey Lap Robe is one of the many products included in the complete Posey Line. Since the introduction of the original Posey Safety Belt in 1937, the Posey Company has specialized in hospital and nursing products which provide maximum patient protection and ease of care. To insure the original quality product always specify the Posey brand name when ordering.

The Posey Safety Lap Robe provides the patient warmth while preventing him from sliding forward or slumping over. This is one of eleven wheelchair safety products providing patient security. #5163-4532, \$21.00.



The Posey Foot-Guard is designed with a rigid plastic shell providing support and synthetic wool liner to prevent pressure sores on heels and ankles. The Posey Line includes twenty-three rehabilitation products. #5163-6410, \$15.00 ea.





The Posey Body Holdermay be used in either a wheelchair or a bed to secure chest, waist or legs. There are sixteen other safety belts in the complete Posey Line. #5163-1731 (with ties), \$5.10.



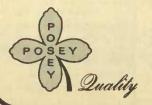
The Posey "V" Safety Roll Belt secures under the bed out of the patienl's reach, yet offers maximum freedom to roll from side to side and sit up. This belt is one of seventeen Posey safety belts which insure patient comfort and security. #5163-1131 (with tie ends), \$9.90.



The Posey Houdini Security Suit, constructed of cool breezeline material, is virtually impossible for patient to remove yet provides security with comfort. There are eight safety vests in the complete Posey Line. #5163-3412, \$15.00.

Send for the free all new POSEY catalog - supersedes all previous editions.

Please insist on Posey Quality - specify the Posey Brand name.



Send your order today!

**POSEY PRODUCTS** Stocked in Canada ENNS & GILMORE LIMITED -1033 Rangeview Road

Port Credit, Ontario, Canada

# in a capsule

Light side of labor

Blood, Sweat & Jeers was the name of the daily newsletter published by nurses during the first (but not last) collective bargaining summer school in Toronto June 3 to 9. The school was conceived and delivered by the Registered Nurses' Association of Ontario.

Although the 47 Ontario RNs who attended worked hard to learn to grieve, their newsletters also show the lighter side of their labor. Here are some excerpts, only slightly edited, from the newsletters:

Help! I am in love with a mature labor relations consultant. He will not

have anything to do with me as I am a scab. — A union maid.

Look alive! You can be replaced by a button.

The Ottawa delegates tested tactics learned at the collective bargaining summer school to persuade the management of a restaurant to pay for their cold and tasteless lasagna.

With the enthusiasm that was shown for this type of school, it is no wonder that a re-union is planned for next year.

Textile care and labeling

Canada has a law, effective June 1,

1973, that requires every manufacturer or dealer to label textiles. The new label has to list the fibers in the fabric, using the family name for each; show the percentage of each fiber by weight; and identify the dealer.

The federal department of consumer and corporate affairs has published a pamphlet about the new law and about the colored symbols, showing the best way to care for and clean garments. The care labels are not required by law, but more and more manufacturers are using them. Pressure from consumers who ask for care labeling can increase the number of manufacturers who tell us how to care for the fabrics we buy.

For a copy of the pamphlet, "Look at that Label," which explains both the Textile Labelling Act and the new care labels, write to: The Consumer, Box 99, Ottawa. The pamphlet is free in limited quantities.

Poor women's rights

In addressing the Canadian Association of Social Workers in Vancouver June 8, Sylva M. Gelber had some sharp criticism for the CASW, which she said has evaded the important issue of the changing status of women in contemporary society.

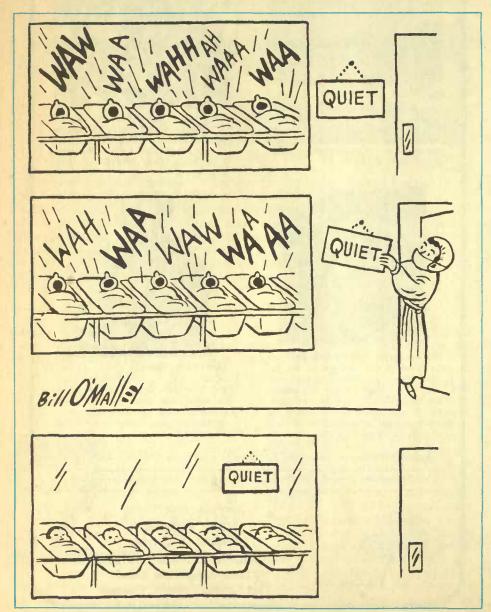
Ms. Gelber, director of the Women's Bureau of the federal department of labor, spoke about humiliating injustices toward women and moral struc-

tures contained in our laws.

For example: "Even the Parliament of Canada has now accepted the thesis that 'the state has no place in the bedrooms of the nation.' But the state is still present in the bedrooms of the poor women of this nation!"

She then referred to the "man in the house" rule that operates in some provincial and municipal welfare programs: "... a woman receiving welfare who lives with a man (not her husband) is given the choice between having her benefits terminated and breaking off the relationship...."

This type of moral stricture, Ms. Gelber said, is also found under Workmen's Compensation law, by which "commissions or boards have the power to discontinue or suspend compensation payments made to the widow of a deceased workman in the event that she lives with a man without being married to him."



# dates

# September 3-6, 1973

Workshop on "Evaluation of Student Nurse Clinical Performance," sponsored by the University of Western Ontario Summer School and Extension Department. For further information, write to: Summer School & Extension Dept., U. of Western Ontario, London 72, Ontario.

# **September 29, 1973**

Sherbrooke Hospital Alumnae Association dinner, Army, Navy Hut, Lennox-ville, Quebec. Reservations must be received by September 17. For further information and reservations contact: Ms. A.L. Momson, 1090 Argyle St., Sherbrooke, Quebec.

# October 1-3, 1973

Association of Registered Nurses of Newfoundland, annual meeting, St. John's, Newfoundland.

## October 1-3, 1973

Annual meeting of the Association of Canadian Medical Colleges and the Association of Canadian Teaching Hospitals, held in conjunction with a meeting of the Canadian Association of University Schools of Nursing, McMaster University Medical Centre, Hamilton, Ontario. For information, write to: Mr. C.A. Casterton, Secretary, Association of Canadian Medical Colleges, 151 Slater St., Ottawa, Ont. K1P 5H3.

# October 8-10, 1973

First congress of World Federation of Neurosurgical Nurses, Tokyo, Japan. Inquiries may be directed to: Ms. Doris McDonald, Charles Le Moyne Hospital, Greenfield Park, Montreal, Quebec.

# October 10-13, 1973

Canadian Association for the Mentally Retarded, national training conference, International Inn, Winnipeg, Manitoba.

### October 15-19, 1973

Tenth annual Australian meeting, Joint World Psychiatric Association, Sydney, Australia. Address enquiries to: Con-AUGUST 1973

gress Secretary, Box 475, G.P.O. Sydney, N.S.W. 2001, Australia.

# October 17-20, 1973

Canadian Council of Cardiovascular Nurses, nursing conference and workshops to be held in conjunction with the annual meetings and scientific sessions of the Canadian Cardiovascular Society and Canadian Heart Foundation, Halifax, Nova Scotia. For further information, write to: Canadian Heart Foundation, Suite 1200, 1 Nicholas St., Ottawa, Ont. K1N 7B7.

# October 21-26, 1973

First annual hospital leadership seminar for hospital management personnel, El Conquistador Hotel, Las Cro-

Sydney, N.S.W. 2001, Australia. further information, write to: Center for Training & Development, U. of Southern California, 311 South Spring

# October 28-November 3, 1973

abas. Puerto Rico. Tuition: \$225. For

St., Los Angeles, Calif., 90013, U.S.A.

International symposium on gonorrhea,

sponsored by the health protection

branch, department of national health

and welfare, Skyline Hotel, Ottawa. For

further information, write to the health

protection branch, Food and Drug

Building, Tunney's Pasture, Ottawa.

October 24-25, 1973

Human relations training program for inservice coordinators in the Atlantic provinces, sponsored by the nurses' associations of New Brunswick, Nova Scotia, Newfoundland and Prince Edward Island with the P.E.I. Leadership Institute of Holland College (Prerequisite: attendance at the earlier "People Power" workshop). Training program will be held in P.E.I. (location not yet settled).

# MOVING? BEING MARRIED?

Be sure to notify us six weeks in advance, otherwise you will likely miss copies.

Attach the Label

From Your Last Issue
OR
Copy Address and Code
Numbers From It Here

# **NEW (NAME) /ADDRESS:**

Street	
City	Zone
Prov./State	Zip
Please complete appr	opriate category:

nurses' assoc.

I hold active membership in provincial

reg. no./perm. cert./ lic. no.

I am a Personal Subscriber.

MAIL TO:

The Canadian Nurse 50 The Driveway OTTAWA, Canada K2P 1E2

# November 5-7, 1973

Association of Nurses of the Province of Quebec, annual meeting, Montreal, Quebec.

# February 18-22, 1974

Course in occupational health nursing, University of Toronto Faculty of Nursing. Fee: \$95. This is offered for registered nurses employed in occupational health nursing. Write to the Faculty of Nursing, Continuing Education Program for Nurses, 50 St. George Street, Toronto.

# June 16-21, 1974

Canadian Nurses' Association annual meeting and convention, to be held in the Manitoba Centennial Centre Concert Hall, Winnipeg, Manitoba.



THE CANADIAN NURSE

# books

Handbook for Camp Nurses and Other Camp Health Workers by Mary Lou Hamessley. 159 pages. New York,

Tiresias, 1973.

Reviewed by Doris Fitzgerald, staff nurse, Ottawa Civic Hospital, Ottawa, Ontario.

This book, prompted by the need for some guidelines for nurses who are or would like to become involved in camp

nursing, meets its objectives.

In the preface, the author clearly and pleasingly reflects the deep satisfaction she has gained from camp nursing, the warm affection she holds for children, and the experiences to be gained in developing a health program for young campers.

The first four chapters describe the physical environment necessary for camps for children, the qualifications and employment conditions for nurses, the organization of health centers within the camp, and the regulations for

camp sanitation.

Chapter five stresses the importance of a camp health program, and the need for complete cooperation and participation of everyone in camp in formulating and carrying out such a program. It states clearly the role each individual in camp must take in maintaining good health, as well as the objectives of a health program.

The dilemma of what to take to camp in the line of clothing, toiletries, and other necessities, can be frustrating to an inexperienced camp nurse. Once on the camp area, it is often difficult or sometimes impossible to obtain articles one may have forgotten. Chapter five would be of great assistance to anyone contemplating a stay in the outdoors.

Chapter seven discusses, in alphabetical order, the illnesses and injuries that may occur in any camp. This chapter is a convenient quick reference. It describes the various problems accurately and intelligently. The treatment proposed for these problems is adequate and sensible. Few, if any, problems have been overlooked by the author. This chapter, along with a Physicians' Desk Reference and a few textbooks on nursing and first aid should give ample information to the camp nurse.

The author makes no mention of the need for some continuity of staff, which is most important for good organization and management of camp life and for the security it provides to both camper and camp worker.

This book is well-written, pleasant to read, with accurate and detailed information involving all aspects of camp life. While the book is directed mainly to camp nurses, it would be of benefit to all personnel involved in the rewarding work at childrens' camps.

Care of the Critically III Child by R.S. Jones and J.B. Owen-Thomas. 323 pages. London, England, Edward Arnold Ltd., 1972. Canadian Agent: Macmillan, Toronto.

Reviewed by Una V. Reid, Laurentian University, School of Nursing.

Sudbury, Ontario.

This book is "the result of the authors' experiences of intensive care" at pediatric hospitals in England and Canada. It is a comprehensive manual dealing with the treatment and care of the critically ill child. The content is focused toward those who work in the intensive care unit, caring for the neonate or the older child.

The book brings together material from physiology, pathology, and re-

search literature.

The first chapter deals with an approach to critical illness; design, staffing, and management of the unit, and parent-staff relationships are discussed.

The chapters on cardiac function, circulatory failure, and respiratory pathology are detailed, well written and supported by various tables, nomograms, and grids. The cardierespiratory aspects of acute diseases are emphasized throughout the text. The preface justifies the emphasis "on the ground that advances in theory and techniques in these major fields dominate treatment."

The concise section on the physiology and physiopathology of the newborn and management of the neonate was written by the chief of the division of perinatology, The Hospital for Sick Children, Toronto. Implications for care of the newborn are focused on the stress and the changes that occur or do not occur during and after delivery. Special care for the neonate, for example, proper resuscitation at birth, oxygen therapy, and regulation of the

thermal environment, is included in the chapter on the eare of the seriously-ill newborn.

Nursing aspects of care are brief and basic. However, the intensive care nurse should be able to assess, plan, implement, and evaluate nursing care, guided by principles from the different aspects of diagnosis and treatment men-

This single book, with its appendixes, provides basic and valuable information for the members of the team of the intensive care units and the neo-natal ward. The delivery room nurse may find useful the chapters on the physiology and physiopathology of the newborn. The book is recommended for those involved in the care of the critically ill child, both at the educational and clinical level.

However, the book is a little advanced for a beginning graduate in any of

the clinical areas mentioned.

The Hospital Emergency Department by James H. Spencer. 360 pages. Springfield, Ill., Charles C. Thomas,

Reviewed by Pamela M. Roberts, Head Nurse, Emergency Department, The Montreal General Hospital, Montreal, Quebec.

The author states in the preface that since World War II the public has become more hospital minded; the doctors have changed their patterns of practice, subsequently the public has turned to outpatient and emergency departments in increasing numbers for medical care, catching most hospitals by surprise. What the reaction has been, and can be, is clearly stated in this book; it does not include details of the treatment. Throughout the 24 chapters, emphasis is placed on the need for improved care with proper facilities for the emergency patient.

The author stresses the importance of good planning and construction, and the need for a well-marked entrance to enable easy access. He discusses in detail the advantages of the open ward technique for receiving critically ill and injured patients, thus improving efficiency. Many examples are given from various hospitals, including illustrations. There are two full chapters

on equipment and supplies, which are realistic and informative to anyone

organizing a new department.

The author says that an administrative committee should be formed within the department to set standards and maintain control. Brief comments are made in regard to staffing and maintenance of permanent emergency room personnel. Dr. Crampton, in his chapter on medical emergencies, gives an excellent account of the cardiac receiving room and prehospital care, together with a choice of equipment. He describes the cardiac ambulance service, at present operating in the U.S.A., performed by nurses and trained cardiac ambulance workers who are in contact by radio or telephone with a physician.

The last chapter of the book evaluates all aspects of the emergency room care. In the author's opinion, the weakest link lies in the care given to the injured at many hospitals in the U.S.A. Should we in Canada be following this more

closely?

This book constitutes a well-planned guide for all who are involved in emergency department planning. It also answers many questions that present themselves from time to time to health care workers.

Mayes' Midwifery: A Textbook for Midwives, 8ed., by Rosemary E. Bailey. 530 pages. London, England, Baillière Tindall, 1972.

Reviewed by Pansy Tewari, Assistant Professor, School of Nursing, University of Windsor, Windsor, Ont.

As a result of recent developments in obstetrics and related sciences, the author has extensively rewritten the text and added several new chapters. Increasing knowledge has provided a better understanding of pregnancy and its effect on the mother and the fetus; in one of the new chapters, "assessing fetal health," several diagnostic procedures, such as fetal blood sampling and ultra sonography, are discussed.

Changing social concepts and the integration of community health and hospital care are included. Some of the topics discussed are family planning, therapeutic abortions, unsupported mothers, and community care services, all providing an opportunity for the midwife to help in the social care of

her patients.

The book has six units: social needs, obstetric anatomy and the fetus, pregnancy, labor, puerperium, and the care of the baby. This book provides material that students, staff members, and instructors should find valuable in maternal and child care.

Orthopaedics and Accidents by Margaret Miller and James H. Miller. 256 pages. London, England, English Universities Press, 1972. Canadian Agent. Musson, Don Mills, Ontario. Reviewed by Anna Gupta, Director, School of Nursing, University of Windsor, Windsor, Ontario.

The editor of the paperback states in his foreword that the book is one of a series of textbooks written specially for students of nursing, midwifery, physiotherapy, radiography, speech training, and hygiene. The series is designed to cover the requirements of the state registration examinations conducted by the General Nursing Council of Great Britain.

The book is written by a husband and wife team: a former ward sister with considerable clinical experience and a consultant orthopedic and accident surgeon from one of the best organized units in the United Kingdom.

The book is divided into two parts: the first part deals with conditions classified according to their pathology, regional groupings, and so on. The principles of fracture treatment and



# instant prints without mess

# disposable FOOTPRINTER

Now you can get perfect footprints of the newborn more easily then ever before. Hollister's Disposable FootPrinter contains just the right amount of Ready-Rolled® Ink for two baby footprints and a correlating print of the mother's thumb or finger. To use, lift from dispenser box, apply to skin, make your print, and dispose of the FootPrinter. You get good prints fast—without the mess of old-fashioned ink-and-roller methods.





HOLLISTER LTD., 332 CONSUMERS ROAD, WILLOWDALE, ONT.
IN CANADA, HOLLISTER LIMITED
IN U.S.A.



the reception of casualties are also included. A full chapter is devoted to the management of major injuries in emergency units of hospitals, giving adequate emphasis to all aspects of nursing responsibilities in such situations.

Part II delves mainly into nursing care of patients in plaster casts and in traction, on common orthopedic operations, and the care of patients undergoing surgery. Special aspects related to positioning, management of pain, wound healing, metabolic response to injury, nursing of children and the elderly, physiotherapy and occupational therapy, radiography, and medical social work are also discussed briefly.

The authors lack the detailed and comprehensive approach to certain aspects of the care of orthopedic patients, particularly the nursing care. Also, there are differences in techniques as well as in types of orthopedic appliances and beds used in Canada. For instance, we use the "log-rolling" technique in turning and changing patients' positions after spinal surgery, whereas the authors write about still using a plaster half-jacket for the purpose.

The main use of the book in Canada would be as a supplement to other references and texts of Canadian or American authors. The book is also useful for a quick review of orthopedics.

# accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, except reference items, may be borrowed by CNA members, schools of nursing and other institutions. Reference (R) items (archive books and directories, almanacs and similar basic books) do not go out on loan. Theses (also R) are on Reserve and may go out on Interlibrary loan only.

Requests for loans should be made on the "Request Form for Accession List" and should be addressed to: The Library, Canadian Nurses' Association, 50 The Driveway, Ottawa, Ont. K2P

No more than *three* titles should be requested at any one time.

BOOKS AND DOCUMENTS

1. The advancement of professional education in Canada. The report of the professional education project (Kellogg — OISE) by John A.B. McLeish. Toronto, Ontario Institute for Studies in Education, 1973, 59p. 2. Annual report of continuing nursing education 1971-72. Vancouver, B.C., British Columbia University, Health Sciences Centre 1972, 93p.

3. Approaches to the human fertility problem. A report prepared for the United Nations Advisory Committee on the applications of science and technology to develop ment: 1968. Chapel Hill, N.C., University of North Carolina, Carolina Population Center, 1971. 99p. (Carolina Population Center. Monograph no.2)

4. The art of writing effective letters, by Rosemary T. Fruehling and Sharon Bouchard. Toronto, McGraw-Hill, 1972. 257p.

5. Collective bargaining for university faculty in Canada, by B.L. Adell and D.D. Carter. Kingston, Ont., Queen's University, Industrial Relations Centre, 1972, 95p.

6. Community health and social services, by Brian Meredith Davies. London, English Universities Press, 1972, 214p.

7. The control of pain, by Frederick Prescott. London, English Universities Press, 1964. 146p.

8. Current issues in nursing education. Papers presented at the Ninth Conference of the Council of Baccalaureate and Higher Degree Programs, New Orleans, Mar. 21-24, 1972. New York, National League for Nursing, 1972. 84p.

9. The definition and measurement of mental health; a symposium held in Washington, D.C. 1966-67. Edited by S.B. Sells. Washington, for sale by the Supt. of Docs., U.S. Govt. Print. Off., 1968. 280p. (U.S. Public Health Service publication no. 1873)

10, Delphi: the Bell Canada experience. Montreal, Bell Canada, Business Planning Group, 1972, 75p.

11. The doctor shortage; an economic diagnosis, by Rashi Fein. Washington, D.C., Brookings Institution, 1967, 199p.

12. Emerging sectors of collective bargaining. Edited by Seymour L. Wolfbein. Morristown, N.J., General Learning Press, 1970. 260p.

13. Evaluation of health programs - an annotated hibliography, by Willy DeGeyndt and Karen B. Ross. Minneapolis, Minn., University of Minnesota, Systems Development Project, 1968. 107p. (Systems Development Project. Comment series no. 8-9(9))

14. An exploration of the future in medical technology, by Frank J. Doyle and Daniel Z. Goodwill. Montreal, Bell Canada, 1971. 66p.

15. Family planning, a curriculum, by London Board of Education. London, Ont., London Free Press, 1973? 89p.

16. Family planning: some facts and/or fables related to birth order, sex ratio, family size, social values, by Vernon E. Weckworth. Minneapolis, Minn., University of Minnesota, Systems Development Project, 1968, 107p. (Systems Development Project. Comment series no. 8-4(7))

17. A family planning survey of Halifax, by

Virginia K. Elahi. Halifax, Dalhousie University, Dept. of Preventive Medicine, Faculty of Medicine, 1973. 218p.

18. The first decade, by Ken MacTaggart. Ottawa, Canadian Medical Association, 1973, 132p.

19. Food and fitness. Chicago, Blue Cross Association, 1973, 96p.

20. Fundamentals of nursing. Edited by Margaret Magnus. Flushing, N:Y., Medical Examination Pub. Co., 1972. 205p. (Nursing examination review book no. 11)

21. Health care: can there be equity? The United States, Sweden, and England, by Odin Waldemar Anderson. Toronto. Wiley, 1972, 273 p.

22. Health hazards of the human environment, prepared by 100 specialists in 15 countries. Geneva, World Health Organization, 1972, 387 p.

23. Health-related research; a bibliography of selected Rand publications. Santa Monica, Calif., Rand Corporation, 1972. 88p.

24. Home care and extended care in a comprehensive prepayment plan, by Arnold V. Hurtado et al. Chicago, Hospital Research and Educational Trust, 1972. 127p.

25. Human resources; obtaining results from people at work, by Edwin J. Singer and John Ramsden. Toronto, McGraw-Hill, 1972. 197p.

26. Les infirmières par L. Davreux et G. Davreux-Collart, Louvain, Belgium, Service d'Information et de Documentation, 1972. 69p. (SID Feuillets d'Information no. 7)

27. Nevada health profile, by Nevada Division, Mountain States Regional Medical Program. Boulder, Col., Western Interstate Commission for Higher Education, 1969, 199p.

28. Nil by mouth? a descriptive study of nursing care in relation to pre-operative fasting, by Stephanie Hamilton Smith. London, Royal College of Nursing and National Council of Nurses of the United Kingdom, 1972. 113p.

29. The nurse as a primary health care provider, by Leslie Perry. Rochester, N.Y., Community Planning Committee for Nursing Education, Rochester and Elmira areas, Genesee Valley Nurses' Association, 1971. 72p.

30. Nutrition and diet therapy; a learning guide for students, by Sue Rodwell Williams, 2ed. St. Louis, Mosby, 1973. 186p.

31. OK, Let's talk about it; dynamics of dialogue, by Cathrina Bauby. Toronto, Van Nostrand Reinhold, 1972. 185p.

32. On dying and denying; a psychiatric study of terminality, by Avery D. Weisman. New York, Behavioral Publications, 1972.

33. Operations research in hospitals; diagnosis & prognosis, by David H. Stimson and Ruth H. Stimson. Chicago, Ill., Hospital Research and Educational Trust, 1972. 110p.

34. Personality and educational achievement, by Frank D. Naylor. Sydney, Wiley & Sons Australasia Pty, 1972. 157p.

35. The physician's assistant-today and

AUGUST 1973

tomorrow, by Alfred M. Sadler et al. New Haven, Conn., Yale University School of Medicine, 1972, 256p.

36. Le planning familial pour les sagesfemmes et les infirmières. Ed. par R.L. Kleinman. London, Fédération Internationale pour le Planning Familial, Comité Médical Central, 1971. 61p.

37. Principles of medicine and medical nursing, by J.C. Houston and Marion G. Stockdale. 2ed. Revised by J.C. Houston and Hilary Hyde White. London, English Universities Press, 1966. 198p.

38. The process of planning nursing care; a theoretical model, by Fay Louise Bower. St. Louis, Mosby, 1972. 139p.

39. Psychology for nurses and the hospital team, by Evryl E. Fisher. Cape Town, S.A., Juta, 1972. 228p.

40. RADAR. Répertoire analytique d'articles de revues du Québec. Préparé par le Centre de Documentation de la Bibliothèque de l'Université Laval. Montréal, Ministère des Affaires culturelles, 1972. 2 vols. R

41. Répertoire des institutions de bien-être pour enfants, adultes personnes âgées & organismes de services communautaires pour la région. Rimouski, P.Q., Centre de consultation sociale de Rimouski, 1971. 1

42. Répertoire mondial des centres de tranement pour maladies vénériennes dans les ports. 3éd. Genève, Organisation Mondiale de la Santé, 1972. 196p.

43. Risques pour la santé du fait de l'environnement, par 100 spécialistes de 15 pays. Genève, Organisation Mondiale de la Santé. 1972, 406p.

44. Rôle de l'infirmière et de la sage-femme en planification familiale. Genève, Organisation Mondiale de la Santé, 1969. 85 p.

45. Rural families and their homes; based on a longitudinal study of Ontario rural families, by Helen C. Abell. Waterloo, Ont., University of Waterloo, Ontario School of Urban and Regional Planning, 1971. I vol.

46. Sex and sex education: a bibliography, by Flora C. Seruya et al. New York, Bowker, 1972, 336p.

47. Social indicators, Proceedings of Canadian Seminar on Social Indicators, First, Ottawa, Jan. 13-14, 1972. Co-ordinator: Novia A.M. Carter. Ottawa, Canadian Council on Social Development, 1972. 182p. 48. Vedettes-matière pour le répertoire canadien sur l'éducation. 4éd. Gary J. Sirois, rédacteur. Ottawa, Conseil canadien pour la recherche en éducation, 1972. 119p.

49. Videocassette technology in American education, by George N. Gordon and Irving A. Falk. Englewood Cliffs, N.J., Educational Technology Publications, 1972. 161p. 50. What do you think? Opinions and attitudes about the economic and general welfare program and other activities of the California Nurses' Association. San Francis-

co, Calif., California Nurses' Association, 1973. 235p.

51. World directory of venereal-disease treatment centres at ports. 3ed. Geneva, World Health Organization, 1972. 196p.

PAMPHLETS

52. A brief to the 'Royal Commission on Nursing. St. John's, Association of Registered Nurses of Newfoundland, 1973. 39p.

53. The continuing education unit; a compilation of selected readings. Edited by Louis E. Phillips. Athens, Ga., University of Georgia Center for Continuing Education, 1972.

54. Current issues in nursing education. Papers presented at the Tenth Conference of the Council of Baccalaureate and Higher Degree Programs, held at St. Louis, Mo., Nov. 15-17, 1972. New York, National League for Nursing, Dept. of Baccalaureate and Higher Degree Programs, 1972. 38p. (NLN publication no. 15-1475)

55. Education for expanded nursing roles in primary health care; a proposal. Vancouver, B.C. British Columbia University. School of Nursing, 1973. 9p.

56. Efficiency versus effectiveness: how these interact in the administration and allocation of funds for health care, by Vernon E. Wechwerth. Minneapolis, Minn., University of Minnesota, Systems Development Project, 1967. Hp. (Systems Development Project. Comment series no. 7-8(1))

57. A first guide of a patient discharge planning program. Don Mills, Ontario Hospital Association, 1972. 11p.

58. 4 years and 44,000 calls; the annual report of the Ottawa Distress Centre. Ottawa, 1973. 19p.

59. Guidelines for the development of health technology programs within the colleges of applied arts and technology and health sciences complexes. Toronto, The Ontario Health Sciences Education Advisory Committee, 1970. 14p.

60. Handbook of syllabuses, 1972. London. Joint Board of Clinical Nursing Studies,

61. The health care of the people of Manitoba. Winnipeg, Manitoba Association of Registered Nurses, 1973. 8p.

62. Independent, dependent, and collaborative functioning and the nursing role, by Betty J. Hallstrom and Karen E. Osterman. Minneapolis, Minn., University of Minnesota, Systems Development Project, 1969. 13p. (Systems Development Project. Comment series no. 9-2(13))

63. On assessing nursing functioning and services; a selected annotated bibliography, by Karen E. Osterman. Minneapolis. Minn., University of Minnesota, Systems Development Project, 1969. 12p. (Systems Development Project. Comment series no. 9-2(14))

64. Outline curriculum in general intensive care nursing for state registered nurses. London, Joint Board of Clinical Nursing Studies, 1972, 15p.

65. Outline curriculum in the nursing of venereal and other sexually transmitted diseases for state enrolled nurses. London, Joint Board of Clinical Nursing Studies, 1972, 9p.



# accession list

66. A proposed plan for the orderly development of nursing education in British Columbia. Part three: continuing nursing education. Vancouver, B.C., Registered Nurses Association of British Columbia, 1973, 30p. 67. Selected abortion statistics; an international summary, by Henry P. David et al. Silver Spring, Md., International Reference Center for Abortion Research, 1973, 41p. 68. A selected annuated hibliography on

68. A selected annotated hibliography on abortion, prepared by Stephen N. Wojcichowsky. Toronto, National Canadian Conference on Abortion, St. Michaels College, 1972, 23p.

69. The student nurse in industry. Guide to use the industrial medical department as a clinical setting for the student. Rev. New York, American Association of Industrial Nurses, Inc., Committee on Education, 1971. 12p.

### **GOVERNMENT DOCUMENTS**

Canada

70. Comité d'Etude des Professions auxiliaires de la Santé. *Document de travail*. Québec, 1971, 191p.

71. Conseil des Sciences du Canada. Aspects

locaux, régionaux et mondiaux des problèmes de qualité de l'air, par R.E. Munn. Ottawa, Information Canada, 1973. 39p. (1ts Etude spéciale no. 24)

72. Conseil Economique du Canada. Exposé annuel, 1972. Ottawa, Imprimeur de la Reine, 1972. 123p. (Its Exposé annuel no. 9) 73. Dept. of National Health and Welfare. How we quit smoking; 78 ex-smokers show what worked for them. Ottawa, Information Canada, 1972. 110p.

74,—. Recommendations of National Conference on Fitness and Health, Dec. 4, 5, and 6, 1972. Ottawa, 1973. 25p.

75. Health and Welfare Canada. National health grant manual 1972. Ottawa. 16p.

76.—. Working paper on social security. Ottawa, 1973. 30p.

77. Laws and statutes. Canada pension plan. S.C. 1964-65, c.51. R.S.C. 1970, c-5. Ottawa. 96p.

78. Ministère de la Santé nationale et du Bien-être social. La formation du psychiâtre complet, par Paul M. Cameron et Stanley E. Greben. Ottawa, 1972, 12p. (Its Supplément de l'hygiène mentale au Canada, no. 72)

79.—. L'expérience intensive de groupe; description et principes, par G.T. Barrett-Lennard. Ottawa, 1973. 12p. (Its Supplément de l'hygiène mentale au Canada, no. 73)

80. Ministry of State for Science and Technology. A house of science and technology (HOST) A study prepared under contract for

the Ministry of State for Science and Technology, The Government of Canada, by a Committee under the auspices of SCITEC, 1972, 22p.

81. National Library of Canada. Research collections in Canadian libraries. Ottawa. 1972. 2 vols. (v.4, universities - Ontario. - v.5, universities - Ouebec)

82. Office du Film. Catalogue des documents audiovisuels, 1972. Distribution générale. Québec, l'Editeur officiel du Québec, 1972, 145 p.

83. Science Council of Canada. Natural resource policy issues in Canada. Ottawa, Information Canada, 1973. 59p. (Its Report no. 19)

84. Statistique Canada. La statistique des hôpitaux. Rapport annuel préliminaire, 1971. Ottawa. 42p.

85. Travail Canada. Organisation de travailleurs au Canada, 1971. Ottawa, Information Canada, 1972, 156p.

86.—. Les femmes dans la population active: faits et données 1971. Ottawa, 1972. 140p.
87. Treasury Board. How your tax dollar is

87. Treasury Board. How your tax dollar is spent 1973-74. Ottawa, Information Canada, 1973. 30p.

# STUDIES DEPOSITED IN CNA REPOSITORY COLLECTION

88. Concerns expressed by patients after hysterectomy, by Wendy Judith Gerhard. London, Ont., 1967. 73p. (Thesis (M.Sc.N.) - Western Ontario) R

# Request Form for "Accession List"

# CANADIAN NURSES' ASSOCIATION LIBRARY

Send this	coupon or facsimile to:		
LIBRARIAN	, Canadian Nurses' Association, 50 The D	Priveway, Ottawa, Ontario. K2P 1E2.	
		in the	issue of The
Canadian	Nurse, or add my name to the waiting	list to receive them when available:	
item No.	Author	Short title (for identification)	
			••••••
*************			•••••
*************			***************************************
***************************************			*******************
	for loans will be filled in order of rece and restricted material must be use		
Borrower		Registration No	***************************************
Position			••••••

Date of request .....

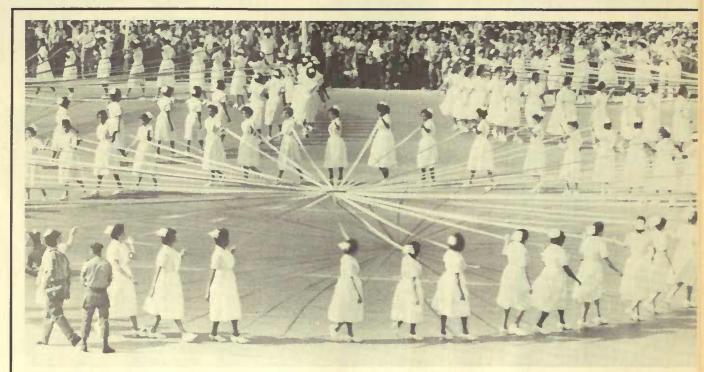
Address

# The

# Canadian Nurse

September 1973







A glimpse of nursing in Cuba



DO NOT TAKE

# FALL IMAGES... BY WHITE SISTER #41303 "ROYALE RIB" knit, ri ribbed polyester blen with nylon. Junior len Sizes 5 - 15. White only About \$2 #1394 "ROYALE RIB" knit, ri ribbed polyester blen with nylon. Sizes 8 White only. About \$2

LBERTA

ne Bay impsons-Sears ogue Dress Shop

**DMONTON** he Bay

aton's ohnstone Walker ose Uniform Shop impsons-Sears

aton's ays Apparel LOYDMINSTER

llen Rick Ltd. ivian Style Shop EDICINE HAT

etite Style Shop
ED DEER

he Bay

RITISH COLUMBIA

impsons-Sears
ORT ST. JOHN

odel Dress Shop

oddard Fashions
AMLOOPS
he Bay

ELOWNA na-Dori Specialty

RINCE GEORGE

DUGHEED ne Bay ENTICTON ne Bay

EVELSTOKE

EVELSTOKE

EVELSTOKE

evelstoke Co-op Associates
IICHMOND
The Bay

MITHERS Ilage Fashions URREY

ne Bay

ERRACE
Prrace Co-op Associates

ne Bay
ANCOUVER
ne Bay
Eaton Co. Ltd.
ermaine's Ltd.
iss K. Raynier

DSE Uniforms

ERNON
THE BAY
TH

mpsons-Sears

ANITOBA

HE PAS
hirl's Boutique
ORTAGE LA PRAIRIE

arr's Fashion

WINNIPEG
The Bay
T. Eaton Co. Ltd.
Rose Lee Fashion Uniforms
265 Kennedy
837 Sherbrook St.

NEW BRUNSWICK
FREDERICTON
Levine's Ltd.
MONCTON
Eaton's
George Battah Ltd.
Simpsons-Sears
SAINT JOHN
Calp's Limited
Manchester, Robertson,
Allison Ltd.
Simpsons-Sears

NEWFOUNDLAND
CORNER BROOK
Sutton's Style Shop
ST. JOHN'S
The London, New York & Paris
Association of Fashions Ltd.

ANTIGONISH
Wilkie Cunningham
DARTMOUTH
Jacobsons of Dartmouth
GLACE BAY
Ein's Ltd.
HALIFAX
Eaton's
The Robert Simpson Co. Ltd.
Uniform Shoppe
SYDNEY
Jacobson's Ladies Wear
Uniform Shop
330 Charlotte St.

ONTARIO BELLEVILLE

**NOVA SCOTIA** 

Jackson Metivier Uniform Shop 265 Front St. McIntosh Bros. 257 Front St. BRAMPTON Purple Pelican

Purple Pelican
Shoppers World Shopping Centre
BRANTFORD
Uniform Shoppe
37 King St.

CHATHAM
Artistic Ladies Wear
Uniform Shoppe
63 Fouth St.
117 King St. West
HAMILTON

HAMILTON
T. Eaton Co. Ltd.
Florence Nightingale Shop
156 James St. S.
Lockharts Ladies Wear
603 Concession St.
The G. W. Robinson Co. Ltd.
18-24 James St. S.
Simpsons-Sears
KINGSTON
Simpsons-Sears
Uniform Shop
20 Montreal St.

KITCHENER Uniform Salon 332 King St. E. Simpsons-Sears The Clothes Tree
1201 Oxford St.
Eaton's
Uniform Centre
Wellington Square
Uniforms Unlimited
723 Richmond St.
MISSISSAUGA
White Dove

58 Dundas St.

OSHAWA
Simpsons-Sears
OTTAWA

OTTAWA
A. J. Freiman
C. Caplan Ltd.
Simpsons-Sears
Uniform World
252 Bank St.
OWEN SOUND

Sylphene's of Owen Sound 854 - 2nd Ave. E. PETERBOROUGH

Uniform Shop 445 St. George St. Simpsons-Sears RENFREW

Uniform World 170 Renfrew Ave. ST. CATHARINES

Magder's Uniform Shop 40 Queenston St. Simpsons-Sears ST. THOMAS Gerrard's Shop

639 Talbot SARNIA Uniform Shop 225 N. Front St. Simpsons-Sears

SUDBURY Uniform Centre 84 Elm St. W. Eaton's

THUNDER BAY
Eaton's
TORONTO
T. Eaton Co. Ltd.
Robert Simpson Co.
Uniform Specialty
1254 Bay St.
372 Queen St. West
Uniform World
641 Bay St.

WELLAND Select Uniform Shoppe 179 King St.

MINDSOR
Adelman's Dept. Store
60 Pitt St. E.
Simpsons-Sears
Uniform Centre
324 Pelissier St.

WOODSTOCK Gerrard's Shop 399 Dundas St.

PRINCE EDWARD ISLAND
CHARLOTTETOWN
Eaton's
Fashion Shoppe
141 George St.
SUMMERSIDE
Smallman's Ltd.

QUEBEC CHICOUTIMI Spécialités Suzette Inc. 418 est, rue Racine 1 Place Saguenay

JONQUIÈRE Corseterie Louise 444 St-Dominique LAUZON

J. E. Paré & Fils

MONTREAL
Eaton's
Uniform Boutique

Uniform Boutique 5729 Côte des Neiges 575 Maisonneuve Blvd. W. 800 St. Catherine St. E. QUEBEC CITY

QUEBEC CITY
Les magasins MIIe Uniforme
1121 rue St-Jean
Lyne Enrg.
2461 boul. Ste-Anne
Place de l'Uniforme
2750 Chemin Ste-Foy
Maurice Pollack Ltd.
750 boul. Charest
Le Syndicat de Québec
405 rue St-Joseph

STE-FOY
Jacqueline Thibeault
2700 Place Laurier
ST-GEORGES DE BEAUCE
Confection Simone

Simpsons-Sears

ST-HYACINTHE
Mme Rita Bibeau Massé

1665 rue des Cascades
TROIS-RIVIÈRES
Maurice Pollack Ltée

SASKATCHEWAN

PRINCE ALBERT
C.B. Department Store
PRINCE RUPERT
Fraser Co. Stores
210 - 3rd Ave. W.

REGINA Eaton's SASKATOON Fashion Uniforms 150 - 2nd Ave. N. Eaton's Simpsons-Sears



PROMINENT DEALERS listed alphabetically by geographic location

CARRY A FINE SELECTION
OF 

IMAGES FOR FALL



For a complimentary pair of white shoelaces, folder showing all the smart Clinic styles, and list of stores selling them, write: THE CLINIC SHOEMAKERS • Dept. CN-9, 7912 Bonhomme Ave. • St. Louis, Mo. 63105

# The Canadian Nurse



A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volu	ime 69, Number 9	September 1973
23	A Glimpse of Nursing in Cuba	H.K. Mussallem
31	Cardiac Surgery in the First Person	M. Guthrie
34	Tropical and Parasitic Diseases: New Challenge to Health Teams	M.M. Lenczner
38	Idea Exchange	

The views expressed in the editorial and various articles are those of the authors and do not necessarily represent the policies or views of the Canadian Nurses' Association,

4	Letters	48	Research Abstracts
7	News	40	AV Aids
18	New Products	52	Books
43	Dates	59	Accession List
44	Names	72	Index to Advertisers

Executive Director: Helen K. Mussallem • Editor: Virginia A. Lindabury • Assistant Editors: Liv-Ellen Lockeberg, Dorothy S. Starr • Editorial Assistant: Carol A. Dworkin • Production Assistant: Elizabeth A. Stanton • Circulation Manager: Beryl Darling • Advertising Manager: Georgina Clarke • Subscription Rates: Canada: one year, \$6.00; two years, \$11.00. Foreign: one year, \$6.50; two years, \$12.00. Single copies: \$1.00 each. Make cheques or money orders payable to the Canadian Nurses' Association. • Change of Address: Six weeks' notice: the old address as well as the new are necessary, together with registration number in a provincial nurses' association, where applicable. Not responsible for journals lost in mail due to errors in address.

Manuscript Information: "The Canadian Nurse" welcomes unsolicited articles. All manuscripts should be typed, double-spaced, on one side of unruled paper leaving wide margins. Manuscripts are accepted for review for exclusive publication. The editor reserves the right to make the usual editorial changes. Photographs (glossy prints) and graphs and diagrams (drawn in india ink on white paper) are welcomed with such articles. The editor is not committed to publish all articles sent, nor to indicate definite dates of publication.

Postage paid in cash at third class rate MONTREAL, P.O. Permit No. 10,001. 50 The Driveway, Ottawa, Ontario. K2P/1E2

Canadian Nurses' Association 1973.

The Association of Nurses of the Province of Quebec has a new name. Now called the Order of Nurses of the Province of Quebec, it enters the fold of parallel organizations that have long been designated as "orders."

One such order, the Order of the Hospital of St. John of Jerusalem, had its beginnings at the time of the Crusades. Founded by the Blessed Gerard, warden of the hospital for Christian pilgrims in Jerusalem, its aim was to relieve human suffering. Throughout many centuries of military grandeur and political upheaval, this purpose has remained steadfast. Even now, the statutes of the order embody the mottoes *Pro Fide* (for the faith) and *Pro Utilitate Hominum* (for the service of mankind).

Although this order nearly faltered during the eighteenth century, it has recovered and branched out to become recognized throughout the world for its distinctive service.

In the early days of settlement in Canada, and later, religious nursing orders figured prominently in establishing hospitals. Their impact, too, has been a lasting one.

At the turn of this century, Lady Aberdeen, the wife of Canada's Governor General, founded the Victorian Order of Nurses. Today, the 900 visiting nurses of this national organization maintain the pioneering spirit of innovation.

Webster's 3rd New International Dictionary defines order as "a narrow, delineated group of persons having a common interest and forming a distinct class by profession, special privileges, or other common interests."

By this definition, order fittingly describes the nearly 40,000 professional nurses of Quebec.

With the enactment of Bill 273, they maintain their rights regarding nursing students (entrance qualifications, enrollment, and so on). Under Bill 250, they retain their dominant role in professional education, which includes responsibility for examinations and clinical instruction of nursing students.

The Order of Nurses of the Province of Quebec has gained strength through new legislation and is now in an even better position to ensure the high quality of nursing care that the public is entitled to expect. In the security of a firmer legal basis on which to build, the rights of professional nurses in Quebec will also be more adequately protected.

--- L.E.L.

# letters

Letters to the editor are welcome.

Only signed letters, which include the writer's complete address, will be considered for publication.

Name will be withheld at the writer's request.

**Educators respond** 

As educators involved in the preparation of nurse practitioners, we believe it is appropriate to respond to the CNA/ CMA joint statement of policy regarding the expanded role of the nurse (May 1973, page 23). Although we agree with many of the points made, we believe there are several that need further definition or exploration.

The joint committee believes, as we do, that the role nurses are assuming is "an evolving one." It is hard, though, for us to see how the responsibilities outlined by the committee to "serve as guides for establishing the activities to be undertaken by nurses" represent any evolution.

We recognize that the responsibilities listed had to be phrased in a general way to allow for flexibility. We cannot, however, read into these generalities any acknowledgement of the nurse practitioner's increased ability to exercise independent judgment in clinical situations. The role outlined is one that most nurses who graduate from a Canadian school of nursing with a baccalaureate or diploma should be able to assume with experience.

This is perhaps why the committee believes that short-term educational programs to prepare nurses for these responsibilities need only be two to four weeks, or conducted on-the-job or in night schools. We wonder how such courses could provide the student with sufficient clinical exposure under qualified supervision that is so necessary for developing clinical judgment.

We believe programs should be conducted within university health science centers, at least during this experimental stage. This would facilitate coordination and integration among the various programs involved in training nurse practitioners, enhance the exchange of information between programs, increase productivity, and reduce duplication of effort. It might also ensure against the production of graduate nurse practitioners with widely differing educational backgrounds and clinical talents. We do not need several new categories of health workers to confuse further the public and the professional. — Phyllis E. Jones, B.Sc.N., M.Sc., professor, faculty of nursing; R.M. Hines, M.D., C.C.F.P., assistant professor and coordinator of group training, department of family and community medicine.

J.E. Boone, M.D., F.R.C.P.(C)., associate professor, pediatrics; B.P. La Perriere, B.Sc.N., educational coordinator. nurse practitioner program; and M. Mc-Culley, B.Sc.N., educational coordinator, nurse practitioner program, University of Toronto, Toronto, Ontario.

Editor's Note: We received an identical letter from faculty at McMaster University in Hamilton, Ontario. It was signed by Dorothy J. Kergin, Reg.N., Ph.D., professor and director, school of nursing; Walter O. Spitzer, M.D., M.H.A., M.P.H., associate professor, clinical epidemiology and biostatistics; Dr. P. Shea, associate program director, family practice nurse program; and E. Mary Buzzell, Reg.N., M.N., M.Ed., director, family practice nurse program.

Research article encouraging

I have read with great interest the article "Staff Nurse Involvement in Research — Myth or Reality?" (June 1973) by Dr. Shirley Stinson. I think nurses have been led to believe that research, a highly scientific enterprise, can only be done by the most carefully prepared individuals.

However, I have always believed that the staff nurse, geared to thinking along research lines, can be more original, methodical, and productive. Dr. Stinson's article was the first I have read that puts research on a practical level. Such involvement by nurses in research programs would encourage more thoughtful

routines.

I congratulate you on publising such refreshing encouragement to us all. We sometimes hesitate to attempt to reach goals that might be considered outside the limits of our present education. This article makes us realize that each day can be thought of in research terms, giving us the opportunity for tremendous accomplishment each year. - Edna Jolly, P.H.N., senior nurse, Minburn-Vermilion Health Unit, Vermilion, Alberta.

Provinces do not cooperate

am writing in reference to Jane Robichaud's letter on registration (July 1973, p.4).

As a result of my experience with registering bodies in Canada, I have concluded there is no such person as "the Canadian nurse, only the provincial nurse." Each province appears to have its own empire and will not accept the evaluation of any other province; indeed, the provinces are not interested in having it any other way.

I am British trained and came to Canada under a recruitment program conducted by the Royal Canadian Air Force. After three years, I married a member of the Armed Services, which

means frequent moves.

My application for registration in a fourth province in Canada was originally refused, although I had more than the required number of hours of theory and practice; had passed the RN examination in Alberta in 1965 and was registered in three other provinces; and had postgraduate experience and references from persons inside and outside Canada. Also, it was less than a year since I had discontinued active nursing.

After 18 months of frustration and several appeals, I was eventually accepted to take the examination again, on the grounds of "safe practice in Canada over a number of years." I have night-mares at the thought of moving to another province, even though I again passed the RN examination in 1973.

I hope the member countries of the International Council of Nurses may one day grant reciprocity to each other. But, after my experiences, I doubt if even interprovincial reciprocity in Canada is possible — Elizabeth Gehman, RN, CMBI (Scotland), Ottawa, Ontario.

### MD finds article instructive

It was my good fortune, when I was researching the literature in my study of "cancer regression by visceral learning," to have my daughter draw my attention to a most interesting and instructive article in your June 1972 issue. This article, written by Linda H. Aiken, was "Systematic Relaxation to Reduce Preoperative Stress.

What impressed my daughter, who is a physician's associate, was that the author was using a technique similar to one I employ in visceral learning. I call this "hypnotic techniques sans hypnosis," and use it with patients who, for any reason, object to hypnosis proper. It is a substitute technique.

(Continued on page 6)

ready now...in dramatic, live action...close-up, full-color (sound or silent) films of birth complications which students rarely have an opportunity to see in the course of their experience in the delivery room.

# Six film sequences demonstrate:

Vertex Delivery	. With Forceps
Vertex Delivery	. Spontaneous
Breech Delivery	
Breech Delivery	
Breech Delivery	
Cesarean Delivery	

Available on six separate Super-8mm film loops (sound or silent), or on one 16mm sound film showing all presentations.

Produced by the School of Nursing and the Department of Obstetrics and Gynecology, School of Medicine, University of Missouri/Columbia.

Vertex Delivery/Spontaneous is available for 15-day PREVIEW on 16mm sound film. A complimentary copy of the Instructor's Guide, which includes narrative scripts for all six birth presentations, accompanies the preview film. We believe this film, together with the complete Instructor's Guide, will convince you that the new "Human Birth" series is indeed outstandingwith superb teaching potential.

# Available in SOUND and SILENT films as follows:

Super-smill optical or magnetic SOOND on
reels or in *Kodak Cartridge\$32.00
Super-8mm SILENT—with superimposed

- titles—on reels or in either Technicolor or Kodak Cartridge .....\$25.00
- 16mm SOUND—All birth presentations in

\*Super-8mm SOUND films can be cartridged for Technicolor, Fairchild or other projectors at \$32.00 per title, plus cost of cartridge. Please write to address shown below for price quotation, giving make and model of projector to be used.

# Teaching advantages of Lippincott Film Loops

For the instructor—lectures can be graphically reinforced. Film loops can be stopped and restarted at any time for emphasis and reinforcement.

In the classroom—there is never a problem with any student unable to see what's going on. Each student has a "front row" seat.

For self-instruction—students can quickly view and review material at their own pace and at a time and place convenient for study.

# Other Lippincott Super 8mm FILM LOOPS (Silent)

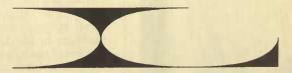
Procedures in Patient Care

- Wound Care (8 loops)
- Urinary Catheterization and Care (9 loops)
- Injection Technic (9 loops)
- Drainage, Suction, Irrigation: Pulmonary and Gastric (15 loops)
- Lifting and Moving Patients (6 loops)
- Positioning and Exercise (3 loops)
- Hygiene (3 loops)
- Asepsis: Medical and Surgical (9 loops)
- Bedmaking (6 loops)

Lippincott film loops can be displayed with the Technicolor Super/8 Movie Projector, or with similar projectors.

Write for illustrated catalog. You may order on a preview basis—all orders promptly filled.

For additional information on the "Human Birth" series, and for our Film Loop Catalog, please write:



J. B. Lippincott Company of Canada Ltd. 75 Horner Avenue, Toronto, Ontario M8Z 4X7 (416) 252-5277

# The least you can do for hospitalized diabetics

It's not that you should do more. It's just that KETO-DIASTIX\* Reagent Strips require the least amount of effort in testing for glucose and ketones in urine. Simply dip into urine and get a semiquantitative reading for glucose and ketones in 30 seconds. What could be easier and less troublesome for you and the patient? Useful all around the hospital. On wards, at the bedside, in patient teaching centers, and in the O.P.D. Also, a good test to recommend for the patient to use at home after discharge. Obtain full details on KETO-DIASTIX by calling your Ames Systems Specialist or by writing to the address below. It's the least work you can do in diabetic urine testing.

# **Keto-Diastix**

Ames Company



Division Miles Laboratories, Ltd.
77 Belfield Road, Rexdale, Ontario



# letters

(Continued from page 4)

Formal hypnosis is much more rapid and effective.

One response I have observed in using my technique in heart surgery is its relaxing effect, which promotes healing and recovery. In my work in cancer regression, I instruct patients to deplete the blood supply to the malignant growth so it will regress to the vanishing point.

Ms. Aiken's technique would be most valuable in any major surgery, and I am sure it would reduce our so-called anesthetic deaths. I have found it of particular value in eye surgery of the aged.

The use of hypnosis by qualified nurses should be encouraged. Are they not using it daily in their duties? The once-feared term is now considered "a known, normal behavior function."

— J.F. Edward, M.D., F.A.S.C.H., Winnipeg, Manitoba.

### Commends authors

I would like to commend Wendy S. Dirksen and Dorothy T. Meilicke for their well-written article, "Surgical Separation of Conjoined Twins" (May 1973).

It is heartening to see the nursing process used so well in planning care for patients; the special needs of these patients were clearly defined. This is a valuable resource for teaching how the nursing process has helped in a unique situation, as well as for helping persons in the future who may need to deal with conjoined twins. — Colleen Stainton, Assistant Professor, Maternal-Child Nursing, University of Calgary, Calgary, Alberta.

Round-the-world perspective

We have spent the past year traveling around the world visiting hospitals, meeting medical personnel, and exploring many facets of nursing. We decided to travel to gain an understanding of nursing roles abroad by exchanging ideas and approaches to mutual problems on an individual level.

In September 1972, we left Montreal aboard the Alexandr Pushkin. The ship's chief surgeon gave us lectures about hospital and community health facilities in the USSR, university education of doctors and nurses, prevalent health problems, and research. We were free to visit the ship's hospital, which contained all the diagnostic and treatment areas for any emergency. The

need to be self-sufficient was emphasized when an appendectomy was performed at sea.

After a one-day stopover in Le Havre, France, we arrived in London and stayed in Great Britain for two and one-half months. When we requested appointments, we stated our purpose and used our letter of reference from the chief of inpatient services, department of psychiatry, at our hospital in Montreal.

In addition to meeting many members of health teams for round-table discussions, we were invited to make home visits with domiciliary nurses, attend staff rounds, make patient rounds, and participate in nurses' study days.

In Edinburgh, Scotland, we were fascinated by the research into the uses of computers in nursing. Hospital administrators and chief nursing officers enabled us to spend time with all levels of nursing staff. We kept hearing the familiar medical concerns facing us today.

After we left England, we traveled by train for three months in Europe.

One outstanding experience was our visit to WHO in Geneva, where the chief nursing officer gave us a wonderful welcome and tour of the building. Her remark, "This is your world—make it the best world you can!" conveyed her enthusiasm for our project. At ICN headquarters, a nurse adviser gave us a unique perspective of the planning for the quadrennial meeting in Mexico, and explained the individual role of nurses in member countries.

In the hospitals we visited in many countries, nurses expressed similar feelings about our profession, giving us a bond of understanding. We also visited several leading pharmaceutical companies and learned about research on drugs. We were impressed by the precision production, quality control, and packaging, designed to minimize medication errors.

In February, we boarded the Italian liner Galileo Galilei for a five-week journey from Italy to Australia.

As we had made prior arrangements, we immediately registered with the New South Wales Nurses' Registration Board in Sydney. For three months, we enjoyed doing familiar work in a psychiatric hospital. On off-duty time, we visited other hospitals, university and rehabilitation centers. It was most rewarding to talk with nurses from many specialties.

We convey our gratitude to all those who helped us discover new horizons in nursing. We hope we never lose this spirit of adventure. — Ann Arundel-Evans and Lynda Cherry, Montreal, Quebec.

# news

**RNAO School Teaches Nurses Collective Bargaining Techniques** 

Toronto, Ont. - Nurses from more than 20 hospital and health unit nursing associations in Ontario spent a week in June learning the rules of collective bargaining strategy. They were participating in the first collective bargaining summer school sponsored by the Registered Nurses' Association of Ontario.

With the help of resource persons, and mock negotiations that lasted one day, many aspects of bargaining were covered, including methods of drawing up demands, grievances, union leadership, and education of members.

Two functions of a staff nurses' association that were stressed during the week were: to learn the essentials of planning and bargaining to get a better collective agreement; and once the agreement is achieved, to police its provisions in the interests of the members to make certain the employer lives up to the agreement.

Trade union consultant William Walsh told the nurses that when a union draws up demands, its leaders must be knowledgeable about what is happening on all issues in other hospitals across the province. Their employers have this information at their fingertips, and rarely accede to a union demand that is not strongly supported by facts, he said.

The union's leadership must present the members with realistic proposals. explained Mr. Walsh. For example, members should know the following facts to determine a reasonable salary demand: wages and working conditions in comparable hospitals, in nonunion hospitals, in the community, in the province, and in the country; consumer price index changes; and trends in recent settlements.

Mr. Walsh advised that nurses' associations make extensive use of the research facilities of RNAO's employment relations department in gathering such information.

When grievances (violations of the eollective agreement) arise, they must be handled under the terms of the collective agreement and within the given time limit, the nurses were told. Issues must be deatt with when they happen. Other important considerations mentioned were the wording of



Trade union consultant William Walsh of Hamilton helped improve nurses' ability to negotiate and supervise collective agreements, at a collective bargaining summer school for Ontario nurses, held in Toronto June 3 to 9. Mr. Walsh was one of the resource persons on hand throughout the week. The Registered Nurses' Association of Ontario sponsored the collective bargaining school.

the grievance, the appropriate redress, and the signing of the grievance by everyone affected.

Four types of grievances were identified: an individual grievance; a group grievance; a policy grievance, in which the interpretation of words is in dispute; and a discipline grievance, in which

facts are in dispute.

George Richards, a member of RNAO's employment relations department, spoke of the importance of education. He said that some unions are so busy negotiating agreements and processing grievances, "they have no time for membership education." A union that follows this pattern, he said, can never prosper.

He reminded the 47 nurses at the school that they will not be powerful if their associations are based entirely on the knowledge and efforts of one or two persons. The summer school "will not succeed unless there is extensive follow-up in the form of local education programs, newsletters, coordinating committee meetings, and even refresher programs to ensure that you... succeed in implementing what you have learned, at the local level."

Speaker At SRNA Meeting Focuses On Women's Work Problems

Yorkton, Sask. - The primary problem women face in their careers is that they are not men, Alice Caplin told more than 300 nurses at the annual meeting of the Saskatchewan Registered Nurses' Association, in June.

Ms. Caplin, an assistant professor at the University of Saskatchewan school of nursing, was speaking about problems women face in their careers. "If women are needed in the work force, we must be respected for what we are, she said.

She noted that society is now being asked to find a synthesis of woman and man based not on generative roles, pity, awe, or financial exploitation, but on true equality and respect. This is what the new morality is all about and is the basis of women's problems in the work world, she added

According to the speaker, some questions working women face are: How can I, as a woman, realize my full potential? How can I resist the factors that work against me? How can I emerge feminine and equal, but not hostile?

Women have to learn to make decisions, to make them stick, and to take responsibility for them, as men have always had to do, said Ms. Caplin. Choosing a career, as distinguished from a job, requires ultimate commitment, she commented.

Dedication to a career, she pointed out, means women have to learn to face loneliness, just as they had to learn to live with the loneliness of marriage. They also have to learn, as men have had to, how to balance a career against the ties of conjugal love and love of children.

Ms. Caplin explained that when women liberate themselves from male standards and from society's stereotypes; stop fearing their own instincts to be intellectual, practical, emotional, and sexual; learn self-respect; and channel their energies on their own behalf, their problems in the work world will decrease.

She urged nurses, as the largest professional group in Canada, to lead the way. "Find out how other women feel about being women. Use your voice and influence to change legislation. Demand that women be appointed to boards. Vote for women. Fight for what is good for you in employment."

Among the things nurses must speak out for, she said, are day care centers, respect as shown by equal pay and opportunity, and a pension plan for women who choose to be housewives.

In her address as outgoing president of SRNA, Jean Pipher told the nurses to communicate their values and concerns to each other, to the public, to related health professionals, and to government. If nurses do not increase the pace of their response to change, she warned, the act of nursing will be taken over by other groups of workers and the profession will disappear.

"Without this kind of activity, we must cease to give lip service to the idea that we have the unity or the power of 6,000 health workers." Ms. Pipher said reforms and changes in nursing must also come from public pressure, which can be created only by a wellinformed public.

# **CNA Membership Increases**

The comparative figures for CNA members in 1970, 1971, and 1972 were included by Dr. Helen Mussallem, executive director of CNA, in her report to the 1973 annual meeting. The figures, by association membership, are:

The state of the	1970	1971	1972
Alberta	9,354	9,754	10,216
British Columbia	11,503	11,905	12,530
Manitoba	5,384	5,466	5,719
New Brunswick	3,632	3,856	4,145
Newfoundland	2,072	2,243	2,204
Nova Scotia	4,648	5,072	5,273
Ontario	13,104	11,579	11,829
Prince Edward Island	698	725	755
Quebec	30,635	32,198	33,391
Saskatchewan	6,097	6,075	6,253
Total	87,127	88,873	92,315

Some of the issues the retiring president saw were regionalization, a larger council with broader representation, a full-time lobbyist, and the need for increased manpower and expertise.

SRNA members approved 17 resolutions at their meeting. Among these were that:

- SRNA encourage more general staff nurses to accept their responsibilities to the organization by letting their names stand for office.
- SRNA develop recommendations regarding qualifications, functions, and salaries for nurses in doctors' offices and such recommendations be made available to the membership of the Saskatchewan Medical Association.
- SRNA recommend to the department of public health and the boards of health of Saskatoon and Regina the amalgamation of existing nursing services and a reduction in the ratio of population per nurse to enable each nurse to provide total family nursing service in an area.
- SRNA encourage its local chapters to involve various disciplines and consumer groups in discussion to bridge the gaps in continuity of health care.
- Members of SRNA assume leadership in physical fitness programs, such as Sport Participation Canada (as demonstrated in Saskatoon), weight control, and antismoking.

A special guest and observer at the annual meeting was Jane Henderson, associate executive director of the Canadian Nurses' Association.

Members At NBARN Annual Meeting Support Various Recommendations Moncton, N.B. — At their annual meeting last May, members of the New Brunswick Association of Registered Nurses approved recommendations on a variety of subjects, including marijuana, the right of a nurse to refrain from certain procedures, and a working definition of nursing practice.

The members supported a proposal of an NBARN ad hoc committee, which recommended against legalizing marijuana, but called for cannabis to be removed from the Narcotic Control Act and included in the Food and Drugs Act. The committee, set up to study the LeDain report on the nonmedical use of drugs, emphasized that "the nursing profession must regard this subject as a professional responsibility of which it must be fully and accurately aware, and must participate in public educa-

One resolution approved by the members stated that "each nurse has the right to refrain from participating in any procedure that conflicts with her moral or religious convictions within legal limits, without prejudice, provided that in emergency situations the patient's right to receive the necessary nursing care would take precedence over exercise of the individual's beliefs and rights.

Also approved was a working definition of nursing, which can be quoted by NBARN members. This definition, developed by the association's ad hoc committee on the expanded role of the nurse, defines the practice of nursing "as those functions which, in collaboration with the clientele and other health workers, have as their objective the promotion of health; prevention of illness; planning, provision and control of nursing care supportive to or restorative of life and well-being. These functions include case finding, observation, assessment, evaluation, health teach-

(Continued on page 9)

# sofra-tulle

# what's in it

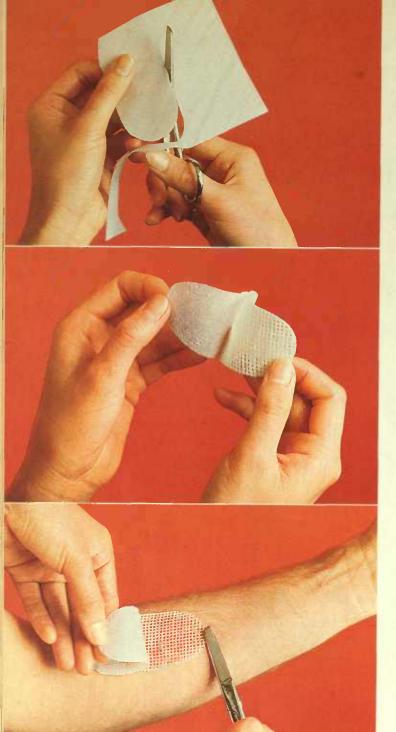
Sofra-Tulle offers you the most effective and convenient antibiotic tulle dressing for wounds, burns and ulcers.

Each Sofra-Tulle dressing sachet is heat-sealed preserve sterility. Easy to handle, the interl tulle can be quickly cut and applied saving valuable time in your crowded day. preserve sterility. Easy to handle, the interleaved



sofra-tulle

single-unit, antibiotic tulle dressing for wounds, burns and ulcers



# sofra-tulle

single-unit, antibiotic tulle dressing for wounds, burns and ulcers

Easy to shape

Each individual dressing is sheathed in sterile parchment for easier handling. Cutting and shaping is neither difficult nor messy with Sofra-Tulle.

# Clean to handle

The overlapping layers of sterile parchment allow even small pieces to be handled withou touching the tulle itself. In this way the sterility of Sofra-Tulle is maintained up to the moment of use.

Simple to apply

The first layer of parchment is removed before positioning the dressing on the lesion and the second only when the sterile tulle is in place. The lanolin in Sofra-Tulle prevents adhesion and simplifies subsequent dressing changes.

### Composition

A lightweight lano-paraffin gauze dressing impregnated with 1% Soframycin.

# Properties

The addition of the antibiotic Soframycin to the paraffin gauze ensures the prevention or eradication of superficial bacterial infections from wounds in a few hours, thereby reducing the need for systemic antibiotics.

Soframycin is active against all staphylococci, and against proteus, Ps. pyocynea and the coliform organisms. It is not inactivated by blood, pus or serum.

Soframycin is very soluble in water and mixes very readily with exudates.

# Advantages

Rapid sterilisation of the wound.
 Excellent mechanical protection.

- No maceration even after three weeks in situ.
- Non-adherent, can be removed painlessly.
- Sensitisation extremely rare.

### Indications

Wounds, burns, ulcers and potentially or secondarily infected skin conditions.

# Contra-indications

Allergy to lanolin or to Soframycin. Organisms resistant to Soframycin.

# Application

If required, the wound may first be cleaned. A single layer of Sofra-Tulle should be applied directly to the wound and covered with an appropriate dressing such as gauze, linen or crepe bandages. In the case of leg ulcers, it is advisable to cut the dressing exactly to the size of the ulcer in order to minimise the risk of sensitisation and not to overlap on the surrounding epidermis. When the infective phase has cleared

the dressing may be changed to a non-impregneone. When the lesion is very exudative it is advise to change the dressing at least once a day.

# **Precautions**

In most cases absorption of the antibiotic is so sl that it can be discounted. Where very large b areas are involved (e.g. 30% or more body burn) possibility of ototoxicity and/or nephrotoxicity be produced, should be remembered.

### Presentation

Sofra-Tulle is presented in cartons of 10 and units, each unit pack containing one sterile a biotic gauze dressing 4" x 4" (10cm x 10cm.)

### or larger body sites

Sofra-Tulle is also available as tins of a single strip 4" x 40" (10cm x 100cm.)

ROUSSEL

Full information available on request.

Payanal (Canada) Ind. 152 Canada Mari

# news

(Continued from page 8)

ing, health counseling, and application of nursing techniques and procedures."

A resolution from the nursing service committee, which was accepted by the members, encourages baccalaureate preparation for directors of nursing, supervisors, and head nurses. NBARN will consider providing two \$500 bursaries annually for such preparation. Another resolution approved requests NBARN to offer financial or other assistance to masters' or doctoral candidates who want to conduct nursing research in the province.

# **RNANS Members Critical Of Report** Of N.S. Council On Health Care

Halifax, N.S. — During the joint nursing seminar and annual meeting of the Registered Nurses' Association of Nova Scotia, held June 14 and 15, nurses strongly criticized the recently published report of the Nova Scotia Health Council on Health Care in the province.

During a panel discussion of "The Future of Nursing in Nova Scotia," the nurses on the panel and in the audience called the report behind the times, contradictory, and in keeping with the "doctors' monopoly" on health ser-

A.B. Balcom, panelist and chairman of the health council, admitted the report was "poorly worded." He suggested "it may be untruthful in places, but not with our intent.'

Delegates passed a resolution that RNANS request a meeting with the minister of health to discuss the implications of the health council report.

Other resolutions passed were:

• that RNANS approach the Hospital Insurance Commission to ask that all nonnursing duties be relegated to the appropriate hospital departments;

 that RNANS study its organization and committee structure with a view to increasing the number of health professionals and members of the public in the association's committee work;

• that every opportunity be used to become more informed on ways to help and protect children by working with other concerned groups;

• that the RNANS research committee continue to further the knowledge and skills of its membership in nursing research: and

• that RNANS ask the Hospital Insurance Commission to provide annually in hospital budgets for a full-time inservice director for hospitals with fewer than 125 beds to ensure that SEPTEMBER 1973

graduates of the two-year program function effectively as beginning practitioners.

# **RNABC Plans To Add Nonnurses To Its Board And Committees**

Vancouver, B.C. - Nonnurse representatives of the public will be added to the board of directors and standing committees of the Registered Nurses' Association of British Columbia.

Geraldine LaPointe, RNABC president, announced this decision in July. She said, "We believe that public representation on our board and standing committees would be a definite asset to the consumer and the nursing profession in making decisions that affect the provision of quality nursing care in British Columbia.'

The association will seek the necessary changes in the Registered Nurses' Act during the legislature's fall session. RNABC's constitution and by-laws will also have to be amended to permit public membership on the board and committees.

At present, the Registered Nurses' Act restricts membership on the board to registered nurse members of the association. On the board are six elected officers and the elected presidents of

RNABC's 12 district groups.

Ms. LaPointe outlined the association's plans. "Once lay representation is possible, we hope to add four nonnurse members to the board of directors and one or two nonnurse members to each of our standing committees. We will approach consumer and labor organizations, government, and our own districts and chapters for nomi-

RNABC plans to appoint two nonnurse members to the board each spring to serve two-year terms.

**SRNA Welcomes Provincial Plan To Set Up Family Planning Program** 

Regina, Sask. — The Saskatchewan Registered Nurses' Association has welcomed the announcement Health Minister Smishek made in June concerning the provincial government's intention to establish "a meaningful and

acceptable family planning program."
"Our only regret," said SRNA past president Jean Pipher, "is that Mr. Smishek did not set a date for implementation and did not indicate a budget allocation for the program." Ms. Pipher said both a publicly-financed family program in Saskatchewan and a government policy with regard to it are long overdue.

The SRNA spokesman noted the association fully supports the recom-(Continued on page 12) LEAD A FASHION #41325 about \$23.00





# UROGATE\* The total system to meet all your irrigating requirements

Solutions
Administration sets
Drainbox\*\*

Now with the Urogate System you can choose from four handy big-mouth bottles.

You'll like the new 500 ml. and 1,000 ml. sizes. They're just right when you need smaller volumes of pour solutions.

Or, where you need *larger* volumes, the familiar 1,500 ml. and 3,000 ml. Urogate containers are ideal.

Those generous 38-mm. openings are built for business! For example, you can empty the new 1,000 ml. bottle in 10 seconds. Or empty the 500 ml. bottle in just 7 seconds.

(Or, when you choose, pour a slow, carefully regulated stream.)

No mix-up with I.V. bottles on your shelf either: you can recognize the distinctive Urogate shape at a glance. What's more, these bottles accept only Urogate urologic sets. No chance of accidental intravenous infusion.

You'll find a choice of Urogate solutions and sets for all your surgical and urologic irrigating needs. It will be worth your while to learn the details. Why not talk to your Abbott Representative this week.

# **Urogate**



Next Month in

# The Canadian Nurse

- Controlling the Fight/Flight Patient
- Hypoglycemia
- Management of Decubitus Ulcers
- A Crisis Center in Action



# Photo credits for September 1973

Julien LeBourdais, Toronto, p. 7

Embassy of Cuba, Ottawa, cover photos, and pp. 24-30

Miller Services Ltd., Toronto, p. 35

The Montreal Children's Hospital, Montreal, p. 38

Penticton Regional Hospital, Penticton, B.C., p. 39

Health and Welfare Canada, Ottawa, p. 46

# news

(Continued from page 9)

mendations in the department of public health's report to the health minister, and is particularly pleased at the emphasis given to education and prevention. "The educational aspect of a program of this nature cannot be overstressed for both providers and consumers of family planning services," Ms. Pipher said.

In May 1972, SRNA announced its support of publicly-financed family planning programs and clinics in a position paper it submitted to the Saskatchewan government. The association urged the government to include family planning as an integral part of its public health program (News, September 1972, p.14).

\$31,500 In CNF Scholarships Awarded To 10 Canadian Nurses

Ottawa — The Canadian Nurses' Foundation (CNF) has awarded \$31,500 to 10 Canadian nurses to pursue graduate studies in the 1973-74 academic year. Awards range from \$3,000 to \$4,500. The nurses, selected for their leadership potential as well as scholastic ability, are:

• Margaret Muir Arklie, Halifax, N.S., \$3,000 to study for a master's degree, majoring in medical-surgical nursing, at the University of Boston, Boston, Mass.

• Sister Marie Bonin, Chateauguay, Que., the Katherine E. MacLaggan Fellowship of \$4,500, for a second year, for doctoral study in education at the University of Ottawa.

• Phyllis M. Craig, Edmonton, Alberta, \$3,000 (the Red Cross Society Fellowship of \$1,750 and a CNF Fellowship of \$1,250) to study for a master's degree in health services administration, majoring in social administration, at the University of Alberta, Edmonton.

• Laurie Naomi Gottlieb, Montreal, Que., \$3,000 to study for a master of science (applied) degree, majoring in maternal and child health, at McGill University, Montreal.

• Barbara Ann Hilton, Toronto, Ont., \$3,000 for a second year (W.B. Saunders Fellowship of \$1,200 and CNF Fellowship of \$1,800) to study for a master of science in nursing degree, majoring in medical-surgical nursing education and research, at the University of Toronto.

• Janet Margaret Holder, Halifax, N.S., \$3,000 to study for a master of science in nursing degree, majoring in advanced community health nursing, at the University of Toronto.

• Phyllis M. Hood, Vancouver, B.C., \$3,000 to study for a master's degree, majoring in family-community health nursing, at the University of Washington, Seattle, Wash.

• Sheila Marie O'Neill, Pointe Claire, Que., \$3,000 to study for a master of science (applied) degree, majoring in nursing administration, at McGill University, Montreal.

• Chantal Rousseau, Montreal, Que., \$3,000, for a second year (the Red Cross Society Fellowship of \$1,750 and CNF Fellowship of \$1,250) to study for a master of science in nursing degree, majoring in education, at the University of Montreal.

• Norma June Stewart, Kyle, Sask., the White Sister Uniform Incorporated Fellowship of \$3,000 to study for a master of science in nursing degree, majoring in psychiatric nursing, at the U. of California, San Francisco, Calif.

Financial assistance has been given to 124 Canadian nurses by the Canadian Nurses' Foundation since its inception in 1962. CNF's funding is entirely voluntary, relying on gifts, donations, and bequests from individual donors and organizations.

In 1972, CNF Fellowships worth \$40,200 were awarded to 14 nurses. The amount of money available for fellowships has decreased since the establishment of the capital trust fund. However, when the trust fund has grown to sufficient size, the income from it will assure an annual amount for fellowships. (News, December 1972, page 11.)

(Continued on page 15)

# It's Winnipeg In '74



The Gateway to the West swings both ways — join nurses from across Canada at CNA's annual meeting and convention in Winnipeg, June 16 to 21, 1974. There is murky water (Cree meaning of Winnipeg) at the juncture of the Assiniboine and Red Rivers, but if you can see your way clear to come, you'll have a "buffalo of a time!" (No whales in the Red River!)

# Pampers 1 Doth abreak

# Keeps him drier

Instead of holding moisture, Pampers hydrophobic top sheet allows it to pass through and get "trapped" in the absorbent wadding underneath. The inner sheet stays drier, and baby's bottom stays drier than it would in cloth diapers.



# Saves you time

Pampers construction helps prevent moisture from soaking through and soiling linens. As a result of this superior containment, shirts, sheets, blankets and bed pads don't have to be changed as often as they would with conventional cloth diapers. And when less time is spent changing linens, those who take care of babies have more time to spend on other tasks.

PROCTER & GAMBLE

New Duotone Design MRS. R. F. JOHNSON SUPERVISOR CHARLENE HAYNES MRS. HOLBRUUN ANN COHN, L.P.N.

# Name Pins 'n Things... from Reeves

# IT'S EASY TO ORDER REEVES NAME PINS FOR YOURSELF OR FRIENDS!

Choose style you want, shown left. Print name (and 2nd line if desired) on dotted lines below. Check other info in boxes on chart, clip this section and attach to coupon

bottom left. Attach extra sheet for additional pins. NOTE SAYINGS ON 2 IDENTICAL PINS... more convenient, spare in case of loss.

BACRGROUNG COLDR (Plastic) DESCRIPTION Engraved 1 Line | Engraved 2 Lines ALL METAL . . . rich, trim and tailored. Lightweight, smooth edges, rounded corners. Does ☐ Black ☐ Dk. Blue ☐ White ☐ 1 Pin 1.98 ☐ 1 Pin 2.58 169 ☐ Silve 2 Pins 3.25 2 Pins 3.85 PLASTIC LAMINATE . . . slimmer, broader; engraved thru surface to contrasting core color. Beveled border matches lettering. White Black ☐ 1 Pin .95 ☐ 1 Pin 1.45 ☐ 2 Pins 1.65 ☐ 2 Pins 2.30 Does 559 Med. Blue apply apply esign; snow-white plastic mooth, polished beyeled f METAL FRAMED | 1 Pi 100 frame smooth, polished beveled frame.

MOLOEO PLASTIC... Simple, smart, economical. Will never discolor.

Smooth rounded corners and edges 1 Pin .95 1 Pin 2 Pins 1.65 2 Pins

\*Please add 25¢ per order for 3 pins or less.

---------

QUANTITY DISCOUNTS: 10-24 pins, deduct 10% \_\_\_\_\_\_



SCOPE SACK neatly carries and protects Nursescope or any scope. Double-thick frosted flexible plastic, white vinyl binding. 4½" x 9½". Your own initials help prevent loss.

No. 223 Sack. . . 1.00 ea. 6 or more 75¢ ea. Your initials gold-stamped, add 50¢ per sack.

# NURSES PERSONALIZED ANEROID SPHYG.

ANCROUD SPITE.

A superb instrument especially designed for aures! Imported from precision craftsmen in W. Germany. Easy-to-attach Veldero cutf. lightweight, compact, fits into soft sim. leather zippered case 2½" x4" x7". Dia Calibrated to 320 mm., 10-year accuracy guaranteed to 230 mm., 10-year accuracy guaranteed to 230 mm., 10-year high superburing similar to the sup No. 106 Sphyg. . . . 32.95 ea.



# MEDI-CARD SET Handiest reference ever! 6 smooth plastic cards (3½" x 5½") crammed with information, including Equivalencies of Apothecary to Métric to Noushold Mess., Temp. "C to "F. Prescrip. Abbr., Urinalysis, Body Chem., Blood Chem., Liver Tests, Bone Marrow, Disasse Incub. Periods, Adult Wgts., Child's Oosages, etc. All in white vinyl holder with gold stamped caduceus. No. 289 Card Set . . . . 1.50 ea. 6 or more 1.10 ea. Your Initials gold-stamped on holder, add 50¢ per set.

KELLY FORCEPS So handy for every nurse! 5½" stainless steel, fully guaranteed ideal for clamping off tubing. Your own initials help prevent loss.

No. 25-72 Forceps . . . 2.75 ea. 6 or more Your initials engraved, add 50¢ per forceps 6 or more 2.50 ea



# CAP ACCESSORIES

(NAI) CAP TOTE keeps your caps crisp and clean while stored or carried. Flexible clear plastic, white trim, zipper, carrying strap, hang loop. Stores flat. Also for wiglets, curlers, etc. 8½" dia, 6" high.

No. 333 Tote . . 2.65 ea., 6 or more . . 2.35 ea. Your initials gold-stamped, add 50¢ per Tote.



WHITE CAP CLIPS firmly in place! Hard-to-find white bobbie pins, enamel on fine spring steel. Eight 2" and eight 3" clips included in plastic snap box. No. 529 Clips . . 3 boxes for 1.95, 6 for 3.25, 12 for 49, ea.

### MOLDED CAP TACS

Replace cap band instantly. Tiny plastic tac, dainty caduceus. Choose Black, Blue, White or Crystal with Gold Caduceus; or all Black (plain). The neater way to fasten bands. No. 200 Set of 6 Tacs . . . 1.25 per set. 12 or more sets 1.00 per set





METAL CAP TACS Pair of dainty jewelry-quality lacs with grippers, holds cap bands securely. Sculptured metal, gold finish, approx. \*\*,\*\*\*" wide. Choose RN, LPN, LVN, RN Caduceus of Plain Caduceus. Gift boxed. No. CT-1 (Specify Initials), No. CT-2 (Plain Cad.) or No. CT-3 (RN Cad.) . . . 2.95 pr.

SEL-FIX CAP BAND Black velvet SELFIX CAP BAND Black velvet band material. Self-adhesive, presses on, pulls off; no sewing or pinning. Reusable several times. Each band 20" long, pre-cut to popular widths: ¼" (12 per plastic box) ½" (B per box) ¼" (6 per box) 1" (6 per box). Specify width under IFEM column on coupon, No. 6343 Band. . . 1.75 per box 3 or more . . 1.50 ea.



	TO REEVES	COMPANY, Box	C , At	tlebor	o. Mass	. 02703
	OROER NO.	ITEM	COLOR	SIZE	OUANT.	PRICE
				- 2		
ı						
			- 8			
	Use	autor di sotto della				_

Use extra sheet for additional items or orders

INITIALS as desired: , for distinctive identification)

TO ORDER NAME PINS, fill out all information in box top right, clip out and attach to this coupon,

l enclose \$ (Mass. residents add 3% S. T.) Sorry, no COD's or billing terms available	
Send to	
Street	
CityStateZip	

# Free Initials and Scope Sack with your own Littmann Nursescope!



diaphragm stethoscope . . . a fine precision instrument, with high sensitivity for blood pressures, apical pulse rate. Only 2 ozs., fits in pocket, with gray vinyl anticollapse tubing, non-chilling epoxy diaphragm. 28" over-all. Non-rotating angled ear tubes and chest piece beau-tifully styled in choice of 5 jewel-like colors: Goldtone, Silvertone, Blue, Green, Pink.\*

FREE INITIALS AND SACK! Your initials engraved FREE on chest piece; lend individ-ual distinction and help prevent loss. Also FREE SCOPE SACK included, worth \$1. as described above right. (Free sacks not personalized; add 50¢ if initials desired.) Ideal for group gifts! Note big sav-ings on quantity orders (left).

No. 216 Nursescope. 13.80 ea. ppd. 6-11...12.80 ea. 12 or more...11.80 ea. Group Discounts <u>include</u> free Initials and Sack! \*IMPORTANT NEW FEATURE: New "Medallion" styling includes tubing in colors to match metal parts. If desired, please add \$1. ea. to all prices above, and add "M" to Order No. (No. 216M) on coupon. Duty free

SCISSORS Precision-made imported forged steel.
Professional quality. Guaranteed 2 years.



31/2" LISTER MINI-SCISSORS Tiny, handy, slip into uniform pocket or purse Choose jewelers Gold or gleaming Chrome plate finish on coupon No. 3500 Mini-Scissors . .

41/2" or 51/2" LISTER SCISSORS As above, but larger for bigger jobs. Chrome finish only No. 4500 (41/2") or No. 5500 (51/2") Spissors . . . 2.75

51/2" OPERATING SCISSORS Stainless steel, with sharp/blunt points. Beautifully polished finish

No. 705 DR Scissors . . 2.75 ea.

All scissors above: 1 doz. or more (any style) . . . . Your initials engraved, add 50c per scissors

CLAYTON DUAL STETHOSCOPE Light weight imported dua) scope; highest sensitivity for appulse rate. Chromed head tubes and chest piece with 1½" bell and 1½" diaphragm, grey anti-collapse tubing, 4 oz., 29" long. Extra ear plugs and diaphragm included. Two initials engraved free.

No. 413 Dual Steth . . . . . . . 17.95 ea.

# **JEWELRY**

# NURSES CHARMS

Finest sculptured Fisher charms.

Sterling or Gold Filled (specify under COLOR on coupon)

For bracelet or pendant chain. Add to your collection! No. 263 Caduceus: No. 164 Cap; No. 68 Grad, Hat; No. 8. Band, Scissors . . 3.49 ea.



14K PIERCED EARRINGS
Dainty, detailed 14K Gold styles, for on or
off duty wear. Shown actual size. Beautifully gift boxed.

fully gift boxed.

Birthstone Colors (specify on coupon): JAN Garnet, FEB Amethyst, MAR Aqua, APR Crystal, MAY Emerald, JUNE Alexandrite, JULY Ruby, AUS Peridot, SEPT Sapphire, OCT Rose Zircon, NOV Topaz, OEC Blue Zircon.

No. 13/297 Caduceus; No. 13/276 Cross; SES per pair.

No. 1/010 Ben. Cultured Pearl; No. 6/247 Birthstone \$ 5.85 per pair.

PIN GUARD Sculptured caduceus chained to your professional letters, each with pinback/ safety catch. Or replace either with class pin for safety. Gold finish, gift boxed. Choose RN. LPN or LVN. No. 3420 Pin Guare. . . . 2.95 ea.



Duty free

ENAMELED PINS Beautifully sculptured status insignia, 2-color keyed, hard-fired enamel on gold plate. Oime-sized, pin-back. Specify RN, LPN, PN, LYN, NA, or

No. 205 Enam. Pin 1.95 ea., 12 or more 1.50 ea.



Smooth, pliable pure white viny low-cost group gifts or favors. No. 210-E (right), two compartments with flap, gold stamped caduceus . . . 6 for 1.50, 25 or more 20 s ea. No. 791 (left) Deluxe Saver, 3 compt. change pocket & key chain . . . 6 for 2.98, 25 or more 35¢ ea.



CDA

CDM

Nurses' POCKET PAL KIT

Handlest for busy nurses. Includes white Deluxe Pocket Saver, with 3½" Lister Scissors Both shown abovel. Tri-Color ballpoint pen plus handsome little pen light — all silver finished. Change compartment, key chain

No. 291 Pal Kit . . . . . . 4.95 ea. 3 Initials engraved on shears, add SO, per kit.

3 or more 3.95 ea.; 6 or more 3.50 ea.



EXAMINING PENLIGHT

White barrel with caduceus imprint, aluminum band and clip. 5" long, U.S. made, batteries included (replacement batteries available any store). Your own light, gift boxed. No. 007 Penlight . . . 3.98 ea. Your Initials engraved, add 50¢ per light.



# w Kork-Lites Featherweight Style



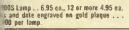
# All-Weather NURSES' CAPE



No. 658 Cape . 3 Gold Initials on collar, add 1.00 per cape.

# HTINGALE LAMP

hentic, unique favor, gift or engraved
Ceramic off-white candleholder with
e gold leaf trim. Recessed candle
andle not included). 7" long.







Endura NURSE'S WATCH Fine Swiss-made waterproof timepiece. Raised easy-to-read white numerals and hands on black dial, luminous markings. Red sweep-second hand. Chrome finish, staniless back. Includes black velvet strap. Gift-boxed, with 1 year guarantee. Very dependable. Includes 3 initials engraved FREE! No. 1093 Nurses Watch . . . . . . . . . 19.95 ea.

No. 1093 Nurses received the control of service for visiting nurses! Finest black 1/2" thick genuine cowhide, beautifully crafted with rugged stitched and rivet construction. Water repellant Roomy interior, with snap-in washable liner and compartments to organize contents. Snap strap holds to open during use. Name card holder on end. Two rugged carrying straps. 6" x 8" x 12". Your initials gold embossed FREE on top. An outstanding value of superb quality. No. 1544-1 Bag (with liner) . . 37.95 ea. Extra liner No. 4415 . . . . . . 6.95 ea.

Fast-Action TOURNIQUET Strong, lightweight Velcro\* Strap applies, adjusts and releases instantly on any limb. Positive holding power, self-adjusting tension, eliminates "pinch". For blood samples, emergencies.

\*\*Duty free\*\*

No. 2017-1 Tourniquet . . . . . 2.69 ea.

oint, with some semblem. Full name semblem. Full name semblem. Full name with coupon). Id-amous ballpoint, with plured caduceus emblem. Full name E engraved on barrel (include name with coupon). Ils avail. everywhere. Lifetime guarantee. 502 Chrome 8.00 ea. No. 6602 12kt, G.F. 11.50 ea.

# TRI-COLOR BALL PEN

Write in black, red and blue with one ball point pen.
the thumb changes point (and color). Steno fine point (excellent
rts). Polished chrome finish. A handy accessory for every nurse! 

HORSESHOE KEY RING Clever, unusual design: one knob unscrews for inserting keys. Fine sterling silver throughout, with sterling sculptured caduceus charm. No bead chain to break! No. 96 Key Ring . . . . . . . . . . 4.95 ea.



# news

(Continued from page 12)

**CHADFOC Will Help Finance Community Health Centers** 

Ottawa — The Canadian Labour Congress has established a national organization, called the Community Health Associations Development Foundation of Canada (CHADFOC), to help local groups across the country set up community health centers.

CHADFOC grew out of union groups' requests to the CLC for assistance in setting up health centers that would

provide 24-hour service.

Jim MacDonald, director of social and community programs for the CLC, told The Canadian Nurse that the CLC has invited other groups to join it in sponsoring CHADFOC. He said the Consumers Association of Canada and the Cooperative Union of Canada have become members of the organization; the Canadian Nurses' Association, Canadian Medical Association, various churches, and agricultural organizations have also expressed interest.

The CLC is seeking a national health grant to employ a team of experts to respond to requests from local groups that want to set up community health centers. This team will be composed of a doctor, a community organizer, an administrator, and probably a research economist, Mr. MacDonald said.

In the CLC's view, there is a need for these health centers because the provision of health care at present is "irrational." Mr. MacDonald explained that medicare pays the bills, but it does not ensure medical care where and when the individual wants it.

The quality of medical care provided by solo practice "leaves a lot to be desired," said the CLC spokesman. "We believe there is a great need for more paramedics, such as nurses and social workers.

Although the health centers will vary greatly, they will have some features in common: they will be initiated by consumers, who will have the major say in their operation; there will be group practice rather than solo practice; each center will employ a medical director who will recruit staff; and 24hour medical care will be available.

The new community health centers will follow the example of union-organized health centers in Ontario and Saskatchewan by centralizing services such as x-ray, minor surgery, physiotherapy, optometry, and central records under one roof.

Practical Nurses At B.C. Hospital Win Equal Pay For Equal Work

Vancouver, B.C. - An arbitration award made in April 1973 gave practical nurses at Kimberley and District General Hospital a pay rate adjustment that brings them up to the rate of pay orderlies receive at the hospital. The province's Human Rights Act, which calls for equal pay for equal work, was cited in the arbitrator's decision.

The practical nurses, who received between \$540.25 and \$562.75 a month in 1973 before the arbitration award was made, now receive a starting salary of \$645.50, \$676.25 after six months, and \$707 after 12 months. The new salaries are retroactive to Jan. 1, 1973.

In his written decision, arbitrator D.R. Blair said the change in the practical nurses' duties and responsibilities since January 1969 justified an upward adjustment in the rate paid for this position.

The arbitrator said that in trying to determine the equitable rate for this position in the hospital's rate structure, one is inevitably led to comparing the duties, responsibilities, and skill requirements of the practical nurse to that of the position of orderly.

Mr. Blair pointed out that the testimony of the hospital's director of nursing "establishes quite clearly ... that these two positions are to all intents

and purposes alike."

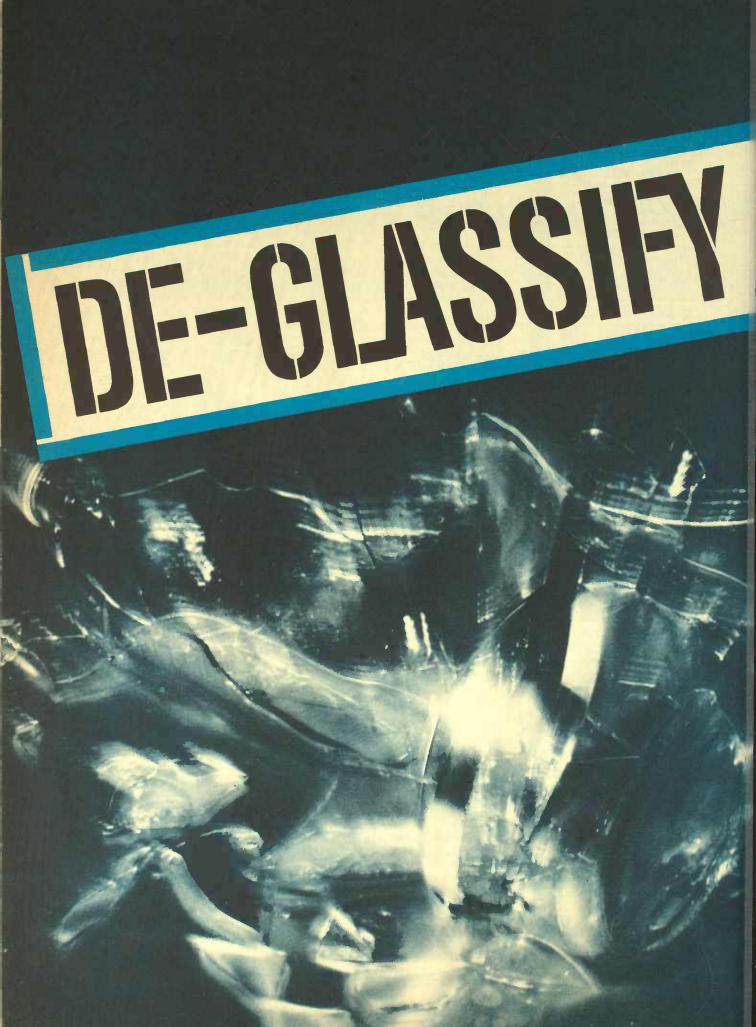
He quoted from the section of the province's Human Rights Act that says: "No employer and no person acting on his behalf shall discriminate between his male and female employees by paying a female employee at a rate of pay less than the rate of pay paid to a male employee employed by him for the same work or substantially the same work done in the same establishment.

The executive director of the Registered Nurses' Association of British Columbia told *The Canadian Nurse*: "We would anticipate that this award, along with other arbitration awards, will have great influence in our coming negotiations."

Under the standard nursing agreement between 73 hospitals in British Columbia and the RNABC, the 1973 salary scale for general staff nurses ranges from \$672 a month to \$842 after six years' experience.

# Countdown 1972

Countdown 1972, a book of Canadian nursing statistics, has recently been published by the Canadian Nurses' Association. Copies are \$5.50 and may be ordered from CNA House, 50 The Driveway, Ottawa, Ont. K2P IE2. Please include payment with the order.



# TAKE THE BOTTLE PROBLEMS OUT OF YOUR IRRIGATION PROCEDURES WITH FLEXIBLE UROMATIC® PLASTIC CONTAINERS

DROP ONE. No breakage. No spillage. No dangerous mess... No cleanup.

FEEL HOW MUCH LIGHTER a plastic container with 3000 ml of solution is . . . 30% lighter than glass.

HANDLE THE SOFT FLEXIBLE CONTAINER. Note how easy it is to get a good grip on it—even when wet.

FORGET THE GLASS BOTTLE JUGGLING ACT. Changeover during surgery is accomplished easily and safely with the UROMATIC containers still hung in the in-use position.

NOTICE THAT THE SOLUTION HAS FEWER BUBBLES. This is a closed system. Air venting is not required so the urologist has greater assurance of a clear, bubble-free view through the scope during the procedure.

DISPOSE OF THE EMPTIES. Soft, flat, practically weightless, ready to drop into any nearby receptacle. Floors are free from the hazards and nuisance of empty bottles.

You probably have enough reasons right now to switch from bottles to the Baxter UROMATIC plastic containers. But here are just a few more. There's the time you don't spend cleaning up a mess of empty bottles or shattered glass. The fingers you don't cut on metal caps and glass fragments. There's the storage space you save with UROMATIC containers. They require approximately 30% less shelf space than glass. And then there's the extra dividend of better dispositions that come with DE-GLASSIFICATION.

So why stay stuck in the glass age, fighting the battle of the bottle? Why not talk to your Baxter representative today and discover how much easier life can be?

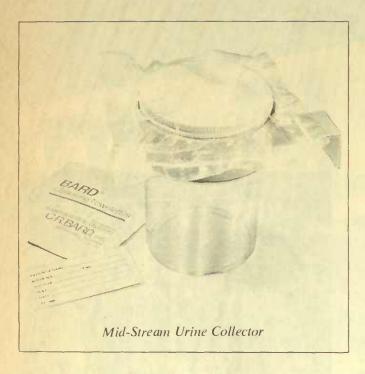


BAXTER LABORATORIES OF CANADA DIVISION OF TRAVENOL LABORATORIES, INC. 6405 Northam Drive, Malton, Ontario



## new products

Descriptions are based on information supplied by the manufacturer. No endorsement is intended.





#### Products from C.R. Bard Ltd.

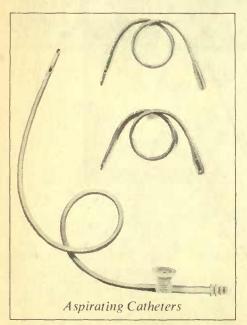
The following products are available from C.R. Bard (Canada) Limited, 1 Westside Drive, Etobicoke, Ontario M9C 1B2.

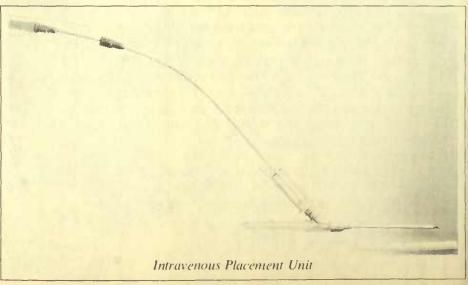
• Single use rubber aspirating catheters, with or without an air-port adapter, are made of radiopaque red latex rubber for firmness and softness. The disposable catheters feature a molded whistle

tip that reduces irritation to delicate mucosa and eyes. The air-port adapter provides fingertip control of suctioning air pressure for a minimum level of suctioning during the introduction and removal of the catheter. The rigid connector provides secure attachment to the suctioning apparatus, and the raised control vent helps prevent contamination during suctioning. The units are supplied in clear, peel-back packaging. • The Bard Advanset intravenous

placement unit is designed to permit

the insertion of a fully radiopaque Teflon catheter into the vein from within an introduction catheter. With this unit, the needle is completely removed and discarded before placement of the catheter. Made in 9, 12, and 24-inch lengths, the two longer lengths have a locking ferrule to permit adjustment of the length of the catheter to be inserted into the vein. A protective sleeve provides for aseptic technique in inserting the catheter. These IV placement units (Continued on page 20)







### W. B. SAUNDERS CO. W CANADA LIMITED

BS 833 Oxford Street
Toronto 18, Canada
Please send and ☐ bill me ☐ send postpaid—check enclosed
☐ 7220 Phillips & Feeney: Cardiac Rhythms About \$10.05 ☐ 6098 Marlow: Textbook of Pediatric Nursing
(4) \$11.10  1696 Bermosk & Corsini: Critical Incidents \$11.85
☐ 4131 Gillies & Alyn: Self-Evaluation (2) \$7.75 ☐ 4528 Harrington & Brener: Renal Failure About \$10.05
☐ 8517 Spencer: Endocrine Problems \$10.05 ☐ 5476 Klaus & Fanaroff: High-Risk Neonate About \$15.45
☐ 2751 Creighton: Law and the Nurse (2) \$7.75 ☐ 1436 Asperheim & Eisenhauer: Pharmacologic Nursing (2) \$8.25
☐ 6355 Miller & Keane: Encyclopedia & Dic- tionary \$9.95
Name
Address
B

CN 9-73

## you want to stay on top of the latest clinical advances, turn to Saunders.

Phillips & Feeney: THE CARDIAC RHYTHMS
A Systematic Approach to Interpretation

A unique self-teaching guide to the recognition and interpretation of cardiac arrhythmias. Examines the effects of cardiac drugs and autonomic nervous system on arrhythmias. By Raymond E. Phillips, M.D., and Mery Kay Feeney, R.N. About 320 pp., 400 ills. About \$10.05 Just Ready.

Marlow: TEXTBOOK OF PEDIATRIC NURSING New 4th Edition Remains unexcelled in its comprehensive treatment of the growth, development and nursing care needs of children from birth through adolescence. By **Dorothy Marlow**, R.N., Ed D. 776 pp. 311 ills. \$11.10. May 1973.

Bermosk & Corsini: CRITICAL INCIDENTS IN NURSING Offers a nurse new insights on how to handle the varied human-relations problems that confront her each day. By Loretta Sue Bermosk, R.N., M.Litt.; and Raymond J. Corsini, Ph.D. 369 pp. \$11.85. June 1973.

Gillies & Alyn: Saunders Tests for SELF-EVALUATION OF NURSING COMPETENCE

New Second Edition provides an easy and reliable volume for review and examination of nursing methods, professional skills and medical facts. By Dee Ann Gillies, R.N., Ed.D. and Irene B. Alyn, R.N., Ph.D. 392 pp. plus 152 answer sheets. \$7.75. January 1973

Harrington & Brener: PATIENT CARE IN RENAL FAILURE A thorough guide to treatment of patients with kidney disorders. Covers hemodialysis, peritoneal dialysis, transplantation, and conservative methods of correcting renal failure. By Joan D. Harrington, R.N., B.S.N., M.A., and Etia Rae Brener, R.N., B.S.N., M.Ed. About 300 pp. Illustd. About \$10.05. Just Ready.

Spencer: PATIENT CARE IN ENDOCRINE PROBLEMS comprehensive, clinically oriented text for nursing care in diseases and disorders of the endocrine system. Reviews physiology and pathophysiology of each endocrine organ and discusses diseases affecting the organ, their freat ment and nursing care. By Roberta T. Spencer, R.N., M.S.N. E. 230 pp. Illustd. \$10.05. January 1973.

Klaus & Fanaroff: CARE OF THE HIGH-RISK NEONATE A practical guide to neonatal management compiled by a team of 19 experts. Each chapter reviews physiologic considerations, clinical recommendations and relevant case problems in question/answer format. Edited by Marshall H. Klaus, M.D. and Avroy A. Fanarott, M.B. (Rand). About 385 pp. Illustd. About \$15.45

Creighton: LAW EVERY NURSE SHOULD KNOW 2nd Edition Explains hundreds of legal aspects of the nurse's career: licensure, employment, negligence and malpractice, "Good Samaritan" laws, more. By Helen Creighton, R.N., J.D. 246 pp. \$7.75 June 1970.

Asperheim & Eisenhauer: PHARMACOLOGIC BASIS OF NURSING CARE 2nd Edition

Offers a complete outline of pharmacology and nursing principles for the busy practicing nurse. Discusses the nurse's expanding role in drug therapy and devotes coverage to principles and techniques of administration. By Mary K. Asperheim, R.N., M.D. and Laurel A. Eisenhauer, R.N., M.S.N. 526 pp. Illusto. \$8.25. January 1973.

Miller & Keane: ENCYCLOPEDIA AND DICTIONARY OF MEDICINE AND NURSING

A comprehensive reference of accurate, up-to-date information. Clear-cut definitions till more than 1000 pages. Full drug data is included. Special sections defail nursing care for most diseases, conditions, and operations. By Benjamin F. Miller, M.D. and Claire B. Keene, R.N., B.S. 1089 pp. 122 ills. \$9.95. March

#### new products

(Continued from page 18)

are individually packaged sterile and pyrogen-free, with complete instructions for use.

• Bard's Mid-Stream urine collector with a new protective collar is individually packaged with cleansing towelettes and a pressure-sensitive label. The protective collar, which is preconnected to handle that protects the specimen container from contamination. The specimen container cap is separately packaged sterile.

• The Bardex Aqua-Matic foley catheter, blue in color, combines a latex formulation with a coating containing Teflon to facilitate insertion. It has an improved storage reservoir that contains a sufficient amount of sterile water to inflate the balloon to its proper size. The improved reservoir adds to the catheter's shelf life and eliminates the need for a separate inflation syringe. The catheter is available as a single unit or as part of several complete procedural trays.

Cough formula

Smith Kline & French Canada Ltd. has introduced Ornade Expectorant Cough Formula, a companion product to its Ornade family of cough and cold remedies.

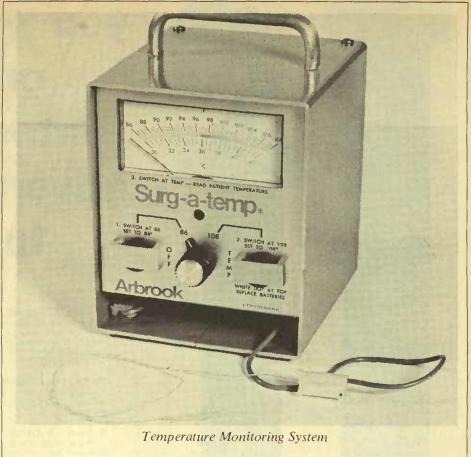
This cough formula is an orange colored, orange-fruit flavored preparation. It is indicated for symptomatic relief of cough and nasal congestion associated with the common cold and other respiratory tract disorders where expectorant activity is desirable. It is supplied in four-fluid-ounce bottles.

Full information is available from Smith Kline & French Canada Ltd., 300 Laurentien Blvd., Montreal 379, P.Q.

#### Arbrook announces new products

The Surg-A-Temp temperature monitoring system and the Vacu-Drain surgical evacuator are two new products offered by Arbrook Ltd., Peterborough, Ontario K9J 7B9.

The temperature monitoring system is used to monitor patient temperatures continuously before, during, and after operations via the tympanic membrane. This compact instrument is self-contained, disposable, and sterile. Using ordinary flashlight batteries for portable operation, it fits on top of the gas machine and can be carried easily from the operating to the recovery room. The





readings are in fahrenheit and centigrade.

The Vacu-Drain surgical evacuator makes closed wound suction quick and simple. With a twist, the wound tubing is connected to the "no-cut" adapter. The top disc is easily compressed to create a vacuum, and the latex membrane assures constant, gentle, negative pressure. The volume of evacuated fluid can be measured by the calibrations on the side of the transparent container. The large port opening provides quick emptying.

SEPTEMBER 1973

20 THE CANADIAN NURSE





Why not have the "black and white cocktail" served in your hospital in the Patient Cup™? The wide-mouth opening of this liquid unit dose container makes it easy for the patient to drink ORGANON'S smooth suspension of Milk of Magnesia and Cascara. (It's pleasant tasting, too.)

Each Patient Cup delivers a stable, precise dose of Magnesium Hydroxide (8%) equivalent to 30 ml. Milk of Magnesia U.S.P., and Cascara Extract equivalent to 5 ml. Aromatic Cascara Fluid extract U.S.P. Alcohol 3.5%.

No mixing. No pouring. No waste. Here is another opportunity for your pharmacy to extend its control of medication right up to the administration of a single dose. And, you'll make some more friends in the nursing department as well.

Order several shippers of Milk of Magnesia-Cascara Suspension. There are 100 doses in each, packed 10 to the shelf tray.

Set 'em up!



The Patient Cup



#### ORGANON CANADA LTD/LTÉE

INTRA MEDICAL PRODUCTS DIVISION TORONTO, CANADA

## A glimpse of nursing in Cuba

Cuba is faced with the health problems of the affluent nations cardiovascular diseases, cancer, respiratory diseases, and accidents. To achieve the same degree of success with these problems as they have with infectious diseases, Cubans will need to promote the role of the nurse to its fullest potential.

Helen K. Mussallem, O.C., R.N., Ed.D.

The Canadian airline folder read. "Go Sun Living — the Bahamas-Jamaiea-Antigua-Barbados-Trinidad and Tobago-Bermuda.... You've got the widest choice under the sun when you go Sun

On a day in late January 1973, many fellow passengers in the Ottawa airport were obviously going "Sun Living" in the Caribbean. I, too, was going to the Caribbean, but on a different and perhaps more stimulating mission. Through the eourtesy of the Embassy of Cuba in Ottawa, I was embarking on what was to become an exciting and enriching professional journey into the world of Cuba's health services, the place of nursing in these services, and the country's social philosophy as it influences its health programs.

Although the visit was short, each of the seven days provided incredible opportunities to observe and gain information. All officials and health personnel in a variety of settings were extremely generous with their time and made every effort to help me gain as broad a perspective of the health scene as could be attained. "Please ask all the questions you wish and let us know what else you want to see," were comments frequently made during the visit. Not once was I discouraged from pursuing my own curiosity. The only limitations were those of time and physical endurance.

Although the primary foeus of my visit was on nursing services and nursing education, I attempted to view the total health effort in relation to the country's economy, social structure, and political organization.

#### The country and its population

Cuba is the largest of the Caribbean islands, being about 745 miles long with a total land mass of approximately 44,000 square miles. Haiti lies about 45 miles to the east, Florida 90 miles to the north, and Mexico 150 miles to

In 1970 the population was 8,553,395, with about 60 percent living in urban areas. Recently, the government implemented a program to reduce the urbanization of the population, particularly in Havana. Resources are being allocated to smaller communities, and new satellite communities are being developed around Havana to attract the urban population.

In one such community, located about 30 miles from Havana, I saw several new apartment blocks and more under construction. The school was already in use and I watched the children assembling for physical exercise. A polyclinic served the new population.

Throughout Cuba I saw great beauty in the historic buildings that were being maintained with limited resources. The old cathedrals and churches were still in use, as no restrictions had been placed on religious freedom after the revolution. I entered one ehurch where a funeral was in progress and saw several nuns, in full traditional habit, among the mourners.

The annual rate of demographic growth in Cuba is 1.7 percent, birth and death rates being 27.3 and 10 per 1,000 respectively. Many senior officials in the health ministry said they hoped the population would increase, as the shortage of manpower in the productive age group (15 to 64) was a serious handicap to the country's development. In comparison with Canada, Cuba has a younger population and a smaller productive age group.

#### Progress in health

Recent observations by Stein and Susser, who visited Cuba under the auspices of the World Health Organization, led them to make this statement: "Before the revolution of 1959, the social and economic conditions and the health patterns of the mass of the people of Cuba were comparable with those of Latin America. With local variations, they were the conditions of developing nations everywhere. Today scarcity persists, but by many indices

Dr. Mussallem is Executive Director of the Canadian Nurses' Association.

the health of the population of Cuba is better than elsewhere in Latin America." <sup>1</sup>

Examples of several of these indices of morbidity and mortality in key diseases are illustrated in the graphs that follow<sup>2</sup> (Figures 1-3.) But first, mention should be made of health statistics in Cuba.

Apparently up to 1959, little attention was given to accurate statistical gathering of morbidity and mortality rates. In the 1950s, only about half the deaths were reported. After 1959, a systematic reporting procedure of morbidity and mortality was developed, and in 1962 this procedure was refined after a conference of consultant epidemiologists. Now, officials affirm that all deaths and their causes are reported through the medical certificate of death.

The response to health campaigns is evident in the morbidity and mortali-

ty rates of poliomyelitis, diphtheria, tuberculosis, acute enteritis, and tetanus.

Before 1962, about 300 cases of poliomyelitis were reported each year. After the massive inoculation campaign of 1962, there was a dramatic drop. (I found it interesting that virtually all children in the country were given the oral vaccine in one day!)

The incidence of *diphtheria* has also decreased because of immunization.

Tuberculosis was a serious health problem up to 1959. A massive BCG campaign was initiated after 1959, and I was told that the serious complications from primary tuberculosis have almost disappeared. The mortality rate from 1959 to 1970 was reduced by 50 percent.

The acute diarrheal diseases have declined with improvement in nutrition and in control of water and food-borne infection. For many travelers the avail-

ability of drinking water is a concern, but in Cuba the water in hotels may be safely consumed.

Although the incidence of *tetanus* dropped by 50 percent between 1963 and 1970, plans have been implemented to ensure further decline. Now the campaign is directed against the high-risk groups in the population.

The *malaria* eradication program began in 1959. In 1962 the morbidity rate was 50 per 100,000 inhabitants. The few cases reported since 1968 were those brought from outside the country. Cuba has achieved eradication of malaria and applied to the World Health Organization for registration of this fact. This recognition has just been received.

The reduction or eradication of major infectious disease in a few years, as revealed by these statistics, is recognized widely as a dramatic public health accomplishment. Today, the main health problems remaining in Cuba are similar to those in Canada — heart disease, cancer, and cerebrovascular diseases. The statistical profile of principal causes of death in Cuba in 1970 resembles that of a so-called developed country, with an aging population and abundant resources.

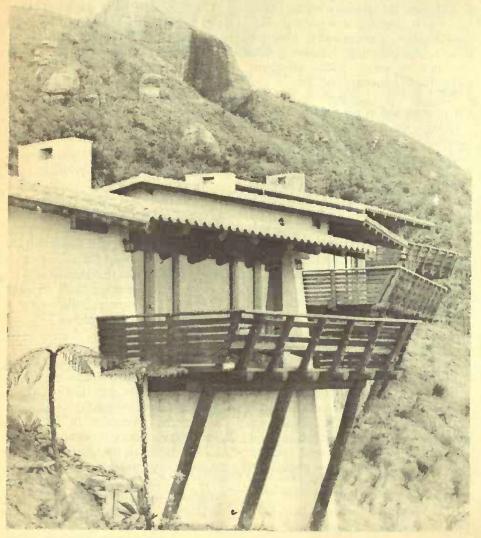
#### Health care available to all

This striking reduction in the morbidity and mortality from infectious diseases is not the only measure of the Cuban accomplishment. Equally impressive is the way in which primary health care has been made available to practically the entire population.

Prior to 1959, health services for residents in many rural areas were almost nonexistent. The sick were earried on horseback for long journeys, or were taken to a coastal area where they might wait several days for the arrival of a boat to transport them to hospital. Many died before arrival. I was told of graveyards at these coastal points for those who, died while awaiting transportation. Today, with better road eonstruction, rapid development of health centers, and more jeeps available, every person now has ready access to eare.

It would be superficial, however, to attribute the Cuban progress in health primarily to effective measures in preventing key diseases, the better organization of health facilities and transportation, and the serious effort to pursue modern planning. With their similar accomplishments in education, housing, and agriculture, it becomes clear that

A tourist center near the top of "La Gran Piedra."



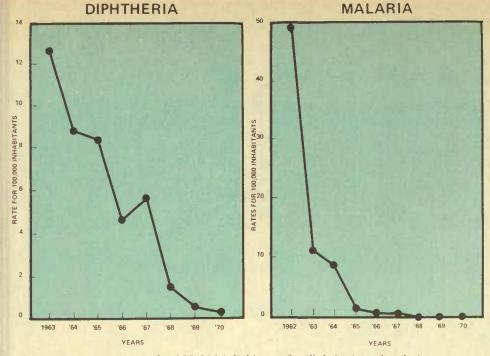


Figure 1: Incidence rates for 100,000 inhabitants for diphtheria and malaria,

back of it all has been a revolutionary change in social philosophy. This philosophy determines not only the direction of governmental policies and the nature of institutional change, but also the quality and content of a host of attitudes and human interactions in every segment of the Cuban society.

This is not the place to elaborate on this topic, even if I were able to do so. Nevertheless, basic to the health story is the premise that the health of the nation, and therefore of the individual, is important for social and economic development. Inequalities, whether by region, social class, or by rural or urban setting, had to be overcome.

Moreover, no social goal is attained simply by laying down a good plan for professional and technical personnel to follow. Health (or education or housing) is the business of the entire citizenry, not because of an abstract principle of "participatory democracy," but because the experience, the imagination, and the capacities of the people are required to attain the goal in both spirit and fact.

From these premises, and taking world experience into account, it follows that health policy and programs would emphasize: (a) preventive, rehabilitative, and curative medicine; (b) planned collaboration between professional, auxiliary, and volunteer personnel, with much reallocation of responsibility to provide wider and more appropriate service; and (c) active participation by the community

in the arrangements of the health service and in their evaluation and improvement.

In Canada, there is growing recognition of the importance of these principles, but we have had great difficulty in applying them widely, particularly in engaging "the consumer" in the working of the health care system. In Cuba, I was most impressed by the importance of the role of mass organizations in interpreting the purpose and nature of health projects to individuals at the grass roots.

The two mass organizations most frequently mentioned were the Committee for the Defense of the Revolution and the Federation of Cuban Women. These organizations are active at the local level — the former being elected by citizens living in defined housing blocks.

In addition to the local committee, these organizations meet at the regional, provincial, and national levels. At each level are the People's Councils, composed of various committees. A key committee in the health service is the People's Commission on Health.

When oral polio vaccine became available, members of the people's organizations worked for weeks, explaining to every family the value of the program. They identified, to the last household, all those who required the preventive measure. Then, on the day set for the project, when all Cuban children requiring this vaccine were ready, only the technical task of ad-

ministering it remained for the health personnel and their assistants.

As an observer of health systems in several countries, I was convinced again that, no matter how well conceived a public health campaign might be, it cannot succeed without the massive participation of individuals at the local level. The spectacular drop in the incidence of infectious diseases in a short period would have been impossible without this web of communication and participation.

#### Structure of health services

The ministry of health is responsible for the Cuban health policy and for health administration, planning, and supervision. It has provincial and regional offices and has a close working relationship with the People's Commission on Health at all levels.

The country is divided into six provinces and one autonomous region (Isle of Pines). In each of the provinces there is a population of approximately 1.25 million. The provinces are divided into regions of about 250,000. The 40 regions in the country are divided into health areas serving about 25,000 persons, and these health areas are divided into sectors.

The Cuban people receive care at three levels — primary, secondary (specialty), and tertiary (superspecialty). These levels have the following facilities.

- Polyclinics (health centers) at the area level, which are responsible for primary health services for approximately 25,000 residents. Each area is divided into sectors related to a population of about 3-5,000. In 1959, there were no polyclinics; at present there are 308.
- Regional hospital centers that provide specialty care services.
- Provincial hospital centers that provide highly specialized or "super-specialty" services.

The sectorial unit, a subsection of the health center, is staffed by a nursing assistant or "auxiliary public health nurse" and one other health worker — usually a sanitarian. The polyclinic staff is responsible for the work in the sector. Its staff includes one full-time director, one full-time nurse, and the services of three or more medical specialists. At least one internist, one obstetrician, one pediatrician, and one dentist work at the polyclinic. In addition to preventive and curative services, the polyclinic provides environ-





mental health services, public health services, and social services.

When I visited the polyclinic, I noted that appointments were scheduled for 6 days a week over a 12-hour period to permit workers to attend at their convenience. In addition to the facilities usually found in health clinics, there were many pieces of equipment used to complete diagnostic tests at the site.

I was also interested to see that the health records of all families in the polyclinic area were kept at the center. These are transferred with families when they move to another region. The director apologized for the lack of computerization of the records, but I assured him that such technological "hardware" had many shortcomings.

Patients may be referred from polyclinics to regional or provincial centers; thus, there is a network of services and referrals from the sector to the specialty/super-specialty services and back to the sector.

Nurses are grouped according to their specialties — adults, children, public health — and work as team members with the various groups and in the settings noted. Nurses in the polyclinics — particularly those whose specialty is public health — seem to work more independently than public health nurses in Canada. They visit homes, assume responsibility for a wide range of medical-technical functions, and supervise and/or maintain up-to-date files on the health status of families in their region, including information on all pregnant women.

Throughout the visit I was impressed by the high priority accorded to maternity services, care of the newborn, and attention to children. (Incidentally, all deliveries take place in hospital.) Three examples may be cited. One is the practice in maternity hospitals of having a nurse visit the home prior to the discharge of the mother and infant to assess its suitability to receive them. A second is the development of nation-wide psychiatric services in which special emphasis is placed on preventive psychiatric services for children, with psychologists carrying out regular assessments of their growth and development. The third is the provision of nutritional supplements for children, including the delivery of one liter of milk daily to each preschool child.

Cuba's manner of expanding and redistributing its supply of hospital beds illustrates well the government's policy of equalization of health benefits in all regions of the country and of sound hospital planning.<sup>3</sup> In 1958 Cuba had 28,536 hospital beds, of which 54.7 percent were in Havana, which had only 22 percent of the population. By 1970, only 40.3 percent of the 40,101 hospital beds were in Havana, where the ratio of beds per 1,000 population declined from 14 to 11.3.

Meanwhile, many small urban hospitals were closed and those in the designated centers were enlarged. Nearly half of the new beds were established in the deprived province of

and monetary rewards, many students prefer to become physicians.

In 1970, almost 30 percent of all new university students were enrolled in the three medical schools, about one-half being women. However, in 1971 a quota was imposed to curb the total number to 20 percent of all university applicants. There are currently about 7,000 practicing physicians.

To compensate for the exodus of about 3,000 physicians after the revolution, a high priority was placed on expansion of the facilities for medical education. From 1959 to 1970, two

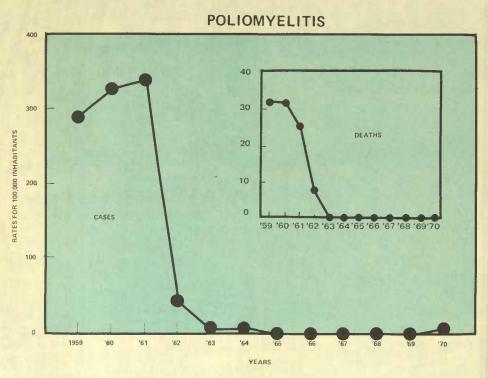


Figure 2: Poliomyelitis: cases and deaths, Cuba 1959-1970.

Oriente, elevating its ratio from 1.6 to 3.7 per 1,000 (1969). In roughly the same period, more than 300 polyclinics or health centers were established, over half in rural regions.

Also, to maintain balance with hospital medicine, a prodigious effort was made to train professionals in public health — 600 in the first three years and over 1,000 in the following five; the latter were trained in a full year, not in an accelerated course.

#### Health manpower

A senior official told me about the projected plans for increases in health manpower, particularly in the numbers of nurses and physicians. In 1958 there were approximately 2,500 practicing nurses; in 1971, this had risen to about 5,000. However, as a medical career is attractive due to its high status

new medical schools were built and about 5,300 new doctors trained.

Physicians, nurses, and other health personnel are salaried and paid according to specialized training and seniority. Only a few doctors in Havana maintain private practice; they were in private practice before 1959. All health workers in Cuba belong to one union regardless of levels of training, status, age, or health discipline.

The goal set for the numbers of nurses to physicians is 3 to 1. There are also plans for increasing the number of auxiliary personnel.

This year, Cuba will be host to the representatives of socialist countries that meet annually to discuss health services, manpower, and education. The 1973 discussion will center on the training of paramedical personnel, including nurses.

Although the gains made in preparation of all health personnel over the past decade are impressive, there is an immediate need to prepare a large number of qualified nurses to fill the gap for this service. This need was identified by health ministry officials, who indicated the problem was receiving priority. If larger numbers are to be attracted into nursing as a career, many factors will require study in depth, especially those factors influencing career choices of young women and the retaining of nurses in the labor force.

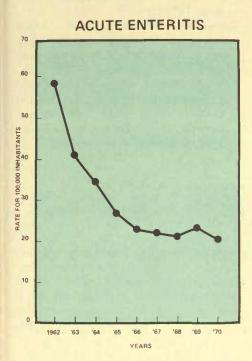


Figure 3: Acute Enteritis: mortality rate for 100,000 inhabitants, Cuba 1962-1970

#### **Education of nurses**

The education of nurses follows 9 years of primary and secondary education and is  $3\frac{1}{2}$  years in length. During this time, some general education is integrated into the program so that on graduation the nurses are at the pre-university level. Students usually enter at 16 years and graduate at  $19\frac{1}{2}$  years. Nursing students have a limited amount of experience in polyclinics and rural areas. Most of their clinical experience is in general or specialized hospitals.

On the other hand, the medical student completes ten years of primary and secondary schooling and a further three years of pre-university study before proceeding to five years at medical school and a one-year internship. This is followed by two years of rural service.

During the last three years of the program, medical students attend one or two half-day sessions weekly in health centers, working under the supervision of a resident or physician. They work each year for a period in sugar cane camps, responsible with a nurse and an auxiliary technical sanitarian for primary care for approximately 2,000 sugar cane workers. A similar experience for nursing students, if feasible, would be invaluable.

Although comments were made on the possibility of a university-based degree program for nurses, no specific plans are under way. I suggested that a core of nurses prepared in a basic program at a university school of nursing might make a unique contribution to leadership in nursing and in health care. I did not feel I made my case sufficiently convincing. I was pleased to learn that no plans were underway to introduce a "feldsher" type of worker.

The 3½-year basic educational program for nurses is hospital-based. It provides a sequence of theory and clinical practice somewhat similar to that of the hospital schools of nursing in Canada, except that more subjects on general education are taught and more experience is provided in public health. During a visit to one school of nursing and a hospital used for student clinical instruction, I was shown the rotation plans for students. These are similar to the rotation plans found in many of our hospital schools of nursing.

The weekly schedule for students is six days. (Graduate nurses work six days per week.) Students from the adjacent area live at home, others are "boarding" students.

Each school of nursing has a full-time nurse director, qualified in teaching and administration from the National School, as well as nurse teachers for theory and nursing practice. Some of the latter teach and supervise students in the nearby hospital. The students' learning experience in polyclinics and rural hospitals is supervised by nurses who meet regularly with the school staff.

Considerable emphasis is placed on the regular evaluation of students in both theory and practice. Each week a meeting of administrative and teaching personnel is held to discuss evaluation and plan programs. For example, in the first week of each month the nurse director holds a meeting to examine the coordination and progress of the course and to identify special problems. The meeting held the second week, composed of teachers, examines identified problems and plans solutions.

The meeting of teachers held the third week focuses on development of new plans. During the fourth week, the director of the school and the director of nursing of the "home" hospital meet together with their senior staffs to discuss various aspects of the program. Directors of nursing from specialized hospitals and student representatives attend, the secretary being a student who is a member of the Communist youth movement. Teachers of "general" subjects, such as chemistry, geography, and mathematics, attend most of these meetings.

Following graduation, the nurse is sent to a special area of need — usually a rural area — for one to two years. However, if the nurse is married, this is taken into consideration so that husband and wife are not separated. I was told that many nurses discontinue active practice because of family needs," but the rate of attrition was not specified.

Postbasic education for nurses is offered at the National Teaching Unit (more than a school of public health), where some 40 courses are taken by 2,059 students (1973). The latter include students in epidemiology, nutrition, sanitation, and health services administration. Here, nurses may enroll in advanced courses for community nursing, obstetrical nursing, pediatric nursing, general or adult nursing, and administration/teaching.

Nurses are selected for these courses on the basis of demonstrated interest, experience, attitude, and political orientation. About two-thirds of each course is taken at the National Unit, and one-third in hospitals or health centers. Graduates in midwifery are fully used in the pre- and postnatal programs; as well, they look after normal deliveries.

#### General comments

Although the one week of observation was well planned and as comprehensive as possible for that short time, it would be presumptuous for me to make anything but general comments.

Certainly from prior study of documents and from observations and discussions, the health of all citizens, regardless of location and status, has been a government priority. Since the revolution 14 years ago, emphasis has been placed on promotion of health and prevention of disease, and new programs have been developed to meet the health goals. Their progress toward

these goals is under continuous, critical evaluation.

The visit gave me an opportunity to assess the role of nurses within the new service. I was greatly impressed by the nurses I met — their vitality, intellectual capacity, and professional commitment — at the ministry, in hospitals, schools of nursing, polyclinics, and so on. I was also struck by the youthful and attractive nursing students with whom I spoke during the visit.

However, in spite of the key role that had obviously been played by nurses in the reorientation of health services, they were grouped together with all paramedical personnel. The reference to the health team was always "doctors and paramedical personnel."

One of the health manpower problems identified during the visit is the lack of sufficient nurses. With approximately 5,000 practicing nurses and 7,000 physicians, a concerted effort will be required to reach the stated goal of three nurses to one physician. This ratio would seem to be appropriate in relation to experiences in other countries and in view of the changing pattern of health problems.

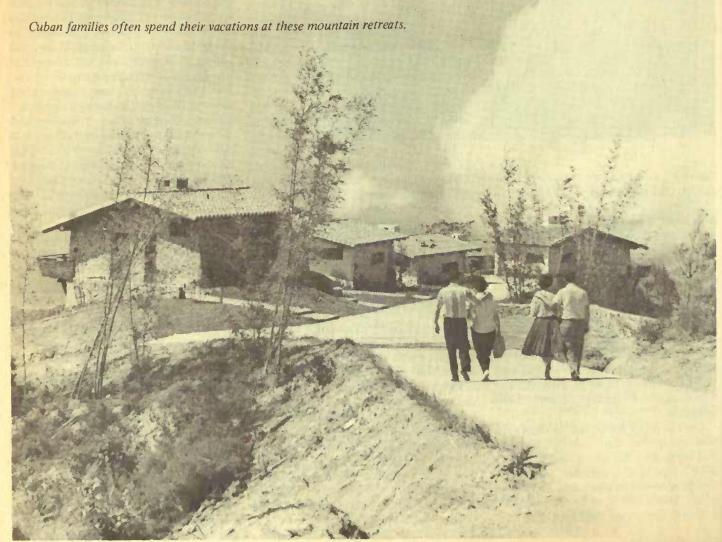
Unlike most countries in Latin America, preventable diseases are under control. Cuba is now faced with the health problems of the affluent nations — cardiovascular diseases, cancer, respiratory diseases, and accidents. To achieve the same degree of success with these problems as with infectious diseases, a great effort will be needed to promote the role of the nurse to its fullest potential. For, as stated in a World Health Organization report: "... in countries where medicine is highly developed and nursing is not, the health status of the people does not reflect the advanced stage of medicine."4

Points that might be considered to attract more women into the nursing profession are: an examination of the present role and status of nurses in the health team, the educational requirements to enter nursing as a career, and the appropriate reward in responsibility

and remuneration. At least one school of nursing should be within a university to add still another dimension to the contribution that nursing could make toward the health goals of the nation.

#### References

- 1. Stein, Z., and Susser, S. The Cuban health system: a trial of a comprehensive service in a poor country. *Int. J. Health Serv.* 2:4:551-66, Nov. 1972.
- 2. República de Cuba. Ministério de Salud Pública. Departamento de Estadística. Salud pública Cuba/71. Habana, 1972 (?)
- 3. Navarro, Vicente. Health, health services, and health planning in Cuba. *Int. J. Health Serv.* 2:3:397-432, Aug. 1972.
- 4. World Health Organization. Expert Committee on Nursing, 1st Session, Geneva, 20-26, Feb. 1950. Report. Geneva, World Health Organization, 1950. (Technical Report no. 24)



SEPTEMBER 1973

## Cardiac surgery in the first person

Heart surgery can be a ravaging experience and can also require a radical change in life-style. The patient needs much understanding, help, and support from family, medical team, hospital staff, and friends.

Margaret Guthrie, B.Sc.N.

The patient who undergoes heart surgery, as 1 did about two years ago, is between 30 and 50 years of age. These are the productive years, the years of enthusiasm, of hope.

This person looks well, is gregarious, intelligent, a doer. His list of accomplishments is long, his potential great. He is an athlete, used to walking and running; he never takes stairs one at a time. He is a perfectionist, but this trait does not trouble him. He does most things well. What does bother him is inefficiency in others. He is quick to give credit, however, where credit is due.

How does heart surgery affect this person? Outwardly, it appears to have had no effect. He still approaches life with enthusiasm. He still looks healthy. Only his family knows what havoc has been wrought. Some of his friends may gain an inkling when, during a dinner party, he has to lie down or when, at the last minute, he cancels a golf game or ski meet.

This person could be clinically diagnosed, "affective psychotic-reactive depression." Usually this depression is cyclic, with cycles determined by how well rested he may be. He frequently contemplates suicide, usually during the night when he cannot sleep. He regards his doctors as either saints or satans: the cardiologists fall into the former category and surgeons into the

latter. His feeling of despair is so great that he cries when he is alone. He tries desperately to adjust his life and accept his limitations, but moderation has never been his strong point. His lifestyle has not prepared him for this.

The above is not imagined. The patient just described is a composite of five individuals I know, and all of them in turn know of others. Each one relates his experience of heart surgery in a different way, but in the long run, one person could be writing everyone's story.

#### My own experience

In 1968, I attended the University of Toronto full time. Although I had a large house to care for, as well as my husband and two children, I was quite active in school events and managed to maintain fairly respectable grades. I became concerned that we should carry more insurance protection for our children, especially as my husband and I were traveling the Gardiner Expressway twice a day.

A doctor was sent to our home to

This is an adaptation of an address given at the founding meeting of the Canadian Council of Cardiovascular Nurses in Montreal, April 9, 1973. The author and her family have few regrets about leaving the city and taking up residence in a small community.

give my husband and me physical examinations. I was turned down for insurance — reason, mitral stenosis. The physician suggested I see a cardiologist soon. He was astounded that I was not already aware I had mitral insufficiency. I was amazed too, as I had given birth to two babies and had had a cholecystectomy in the past five years.

I saw an internist, who questioned my reasons for working and suggested I slow down a bit. He intimidated my determination to work by pointing out that, if I took care of myself, the need for surgery could be 10 years or more away. I never really discussed this appointment with anyone, beyond declaring that I was fine and surgery would not be required for a long time. I was embarked on a course that I felt compelled to finish. This included my two-year obligation to the nursing school. For the eighteen months after graduation, I carried a heavy classroom teaching load in addition to my work in clinical supervision.

In the fall of 1970, worried about my energy level, weight loss, persistent cough, and periodic fibrillation, I made an appointment with my general practitioner in the hope that he would refer me to a cardiologist. Instead, he made an appointment with a heart surgeon.

The heart surgeon inspired great

THE CANADIAN NURSE 31

confidence. He assured me I could be fixed up and that I would feel like a new person. The danger of a cardiovascular accident inherent in a fibrillating heart would also be removed. I was then referred to a cardiologist who was to determine if any calcium had built up in the valve. If so, then we would defer the surgery to a later date. (I might have needed anticoagulants the rest of my life!)

When I saw the cardiologist, we decided to go ahead with the surgery after Christmas. I was impressed with the thoroughness of both the surgeon and the cardiologist and felt confident I was doing the right thing. But I cried all the way home.

Preparing for surgery

For the next month, I worked hard during the day and walked the floors all night. At one point I phoned the surgeon to ask for something to relax me, but was told by his nurse they did not do that sort of thing and that perhaps I would like to have the surgery earlier.

By this time, I was convinced that this would be my last Christmas with the boys, and therefore the date after the New Year should stand.

As the day approached, I systematically organized my affairs. I determined the distribution of my jewelry and planned my funeral. I even picked out a new wife for my husband and mother for our boys. Imagine you are driving down a busy street, when a car moves into your lane. You don't have time to stop. You jam on the brakes, but fear grips your heart as you know you are going to hit. That type of fear engulfs the patient as he or she enters hospital.

I arrived at the hospital at the appointed time long before supper, and was admitted to the floor two hours later, well after supper. It was a good hour-and-a-half after that before I saw a nurse. I never did get supper that night, which was just as well, as it would have stuck in my throat anyway.

#### The floor — presurgical

Soon after admission, it became obvious that there was "intensive care" and over there was "the floor." The nurses were too busy and overworked to have time for the floor. We saw a

registered nurse at medication and treatment time, and that was it.

The hostility of the other patients on the floor was disturbing; but as a nurse I could readily see the problem, and, as I was fairly well, I tried to help out where I could. I listened to patients and their families and offered reassurance when needed.

At night, I did not have this diversion to preoccupy my mind, so I walked the floor, stared out the window, and cried some more. I finally dropped off to sleep in the early hours of the morning. I was soon awakened with a start as the surgical team streamed in. These ward rounds, to my mind, do more harm to the patient psychologically than any other single event. They are humiliating, depersonalizing, and have no redeeming quality. I felt like a thing when they were over. Not one of the team even looked at me, let alone acknowledged my existence. I felt just like so much meat.

After two days in hospital, I had still not seen my surgeon. I was told he was there and would be around. The floor grapevine, which is pretty fast, whispered that the "boys" were having trouble. Things weren't going very well

Meanwhile, the postsurgical patients walked the halls, showing off their scars, and terrifying the prospective lineup. I met one man who chain smoked from early morning to late at night. The nurses begged, pleaded and scolded, and finally took away his cigarettes. He had them hidden, however, on every floor in the hospital. His favorite place was the doctors' lecture room, where he would slip in and smoke to his heart's content. He even caught the occasional lecture. His roommate, on the other hand, hardly moved from his room. He was a model patient. You can guess what's coming. Our smoking friend sailed through surgery; the model patient died of infection two weeks later.

The day before surgery I was climbing the walls. I asked to see my former director of nursing, whom I knew was now working in an executive capacity in this hospital. She came and sat down to talk to me. I will be grateful forever for her kindness and support, not only to me, but to my husband and family. She was the only nurse who ever sat

down and expressed the feeling, "you are going through a rough time; but I am here to help you get through it." This same nurse accompanied me to surgery and was in the recovery room when the operation was over.

I mentioned before that, until the day before surgery, I had not seen the surgeon. So I made a declaration to be attached to my chart. It said, in effect: "If I should have a cardiac arrest following my return to the floor, I do not wish to be resuscitated." I also refused to sign my consent until I had seen the surgeon. Well, you must believe this caused a flurry. Up came the surgeon with a retinue half-way round the room. He was obviously annoyed with me, and I was full of guilt feelings. But, a funny thing, I slept that night — at least people knew I was around.

#### Intensive care — postsurgical

Intensive care was a safe retreat for me after surgery. I was not frightened by the experience, perhaps because I was so familiar with the surroundings. I could tell when the anticoagulant was running through because it felt like warm water washing over my hand. This sensation persisted for weeks after the operation and long after the intravenous was discontinued. The thoracic tubes were not too painful, unless I was asleep when someone decided to milk them.

My main physical problems were a stiff neck and a gagging sore throat, the latter caused by the Levin tube. During "rounds" early one morning, I beckoned to one of the junior members of the team and asked to have the tube out. He agreed and gave the order verbally to one of the nurses. As soon as the team had gone, I figured this tube should come out right there and then. I was told, "Hold your horses, Ms. Guthrie, we'll take it out in due course." It was two hours later when someone finally delivered me from my misery. (I stress to my students the importance of getting the Levin tube out at once.)

I remember sitting on a bedpan one night and trying at the same time to cough up some mucus. No one offered to splint my chest or to give a girl a hand. I don't recall any meaningful dialogue taking place in the unit. Is it taboo to talk to patients in this area?

SEPTEMBER 1973

The nurses talked at their patients, never to them or with them.

Moving from intensive care was a real production. Not only did the patients in intensive care move, but the whole floor moved. It seemed to me that the nurses should have aligned themselves with the movers' local, as many valuable nursing hours were wasted in this endeavor.

The transition to the "floor" was quite a shock. It seemed I was on my own now. The surgery was a success, and how fast I recovered was up to me. This transistion period has been discussed at great length by my fellow heart patients, and we all agree it is a

hard time to go through.

I believe the surgeons take a look at your cardiac output prior to surgery and, after enlarging or repairing the faulty mechanism, expect your output to be much greater — increased cardiac output should lead to a healthier person. But this supposition does not recognize that the chest has been literally pried apart with retractors and that the heart has been assaulted; nor does it allow for the shock to the whole system.

#### Nursing support needed

In any first-year medical-surgical text where heart surgery is discussed, mention is made of the postoperative depression. Many theories are put forth as to causative factors, one of them being the state of isolation in intensive care. Another theory suggests that one's time on the pump is directly related to the degree of depression. My theory is that the lack of nursing support in the period after leaving intensive care is directly responsible for this depression.

It is common to perspire profusely after surgery. One of my friends got up every night and changed his own soaking wet bed. On his third postoperative day, he washed his hair. This man had his surgery in another hospital, but he blames this sanctioned activity for a myocardial infarction he suffered 10

days postoperatively.

One night, when in great pain, I rang to ask for some medication. I was told "If you want something for pain, you'll have to come and get it." So I got out of bed, clung to the wall, and made my way to the nursing station. Let me tell you, in a situation like this the patient feels like telling the nurse what she can do with those pills.

A heart unit should not exist if there is not enough money to staff it properly. There is so much more to nursing than running machines and passing out pills. An overworked nurse is not blessed with the quality of mercy, and

her strain affects the patient.

Nine days after surgery, I was transferred to a convalescent hospital. I balked at the idea of going at first, but relented. I certainly was not sorry for this decision. To my surprise, I saw more registered nurses there than were ever on duty in the heart unit. These nurses were most supportive. They assisted, rather than pushed. They allowed you to relax and feel human again. They never appeared hurried.

#### Home again

On discharge from hospital, I asked what I could do. The answer was, "anything." To someone like myself, this is like waving a red flag because, for the next two months, I spent two days up doing anything and two days down doing nothing. This was most discouraging but, after assurances from the doctors that all was well, I returned to work part time. That lasted two weeks, and by the middle of April (1 had the surgery in January) I was back at it full tilt.

During the summer, I came to the conclusion that I had to slow down. It was decided that I should switch to teaching the first-year program where the clinical hours were fewer. I worked the next year in this capacity and began to feel that this, too, was at times more than I could handle. Many a night I have made supper, but have not been able to eat it. An overwhelming feeling of exhaustion comes over me and I have to give in to it. I have to go to bed.

Last June my husband and I made the decision to leave Toronto and move to Meaford, Ontario, a town on Georgian Bay near our cottage. I now work nine days a month as a public health nurse in Owen Sound. I would love to go back to teaching and to the hospital but, frankly, I do not think I could handle it physically.

I still have trouble sleeping and routinely take 5 mg. Vivol to help me sleep. I am discouraged because I don't

feel great, and my productivity is decreasing each year. I realize I have been unable to accept my limitations, because no one has ever suggested that I have any.

#### Conclusion

I would like to make some recommendations for nurses regarding the heart surgical patient.

- Take a nursing history on admission to the unit. This does not have to be long or involved, but the patient should be given the opportunity to express his or her fears at the very outset of care.
- As the preoperative period is just as important as any other, allot time to adequately prepare the patient psychologically, as well as physically.

• Quit treating every patient on an assembly line basis. By withdrawing your support, you promote, rather than prevent, a cardiac cripple.

- Stop telling every patient he is going to feel great. I think some research is needed here, and patient follow-up is the only answer. What expectations should this patient have postoperatively? He has a right to know, and none of us seems able to tell him.
- Give an itemized written outline to every patient on discharge from hospital. This should be individualized as to diet, medication, and exercise. The patient should be told what to expect. For example, sleeplessness is not uncommon, there will be periods of depression, and chest pain can be expected periodically up to two years. These symptoms are due to fatigue, so the patient should try to keep well rested.
- Finally, to all nurses, try to maintain a sense of humor. On the end of those monitor leads is a person who would appreciate it.

## Tropical and parasitic diseases: new challenge to health teams

Rapid intercontinental travel and other factors have extended certain health problems, such as tropical and parasitic diseases. Health workers in Canada must increase their knowledge of these diseases.

Michael M. Lenczner, M.D., F.R.C.P. (C)

Since the turn of the century, Canada has enjoyed one of the highest standards of public health in the world. Safe water, pasteurized milk, proper housing and sanitary facilities, control of communicable diseases, monitoring of food handling, and food quality are prime examples of our society's protective mechanisms. These are not always found in other countries, especially in tropical, subtropical, and developing nations.

Rapid intercontinental communications, frequent mixing of populations, and changes in the composition of our communities have extended health problems on a world-wide basis beyond our frontiers. Because of this, tropical and parasitic diseases are an increasing part of common medical practice. All health workers must increase their knowledge of these diseases.

The type of infection or infestation depends on the geographical area in which the disease has been contracted, as certain diseases depend on special climatic conditions, insect vectors, and intermediate hosts for their development and transmission.

Early recognition and treatment of tropical and parasitic diseases are obviously of great importance to the individual and the community. Some of these entities include: 1. infectious diseases, such as amebiasis, salmonel-

losis, shigellosis, and giardiasis; 2. contagious diseases, such as trichuriasis, enterobiasis, ascariasis, and skin infections; and 3. crippling diseases, if untreated, such as filariasis, loiasis, ankylostomiasis, strongyloidiasis, and trypanosomiasis.

As the symptoms of parasitic infection are often not specific, the prerequisite for the diagnosis is everlasting suspicion. The lack of striking specific symptoms leads to much unsatisfactory and prolonged treatment and frequently breeds psychoneurotic states.

A knowledge of geographical distribution of diseases — especially those that require an intermediate host and carrier — an accurate history, and knowledge of the travels of the patient are basis requirements when making a diagnosis. Direct demonstration of parasites in blood, tissues, stools, or urine is still the preferred diagnostic method.

Recent advances in parasitic immunology offer new standardized antigens and serological methods for

Dr. Lenczner is Professor, Department of Medicine, University of Toronto, and Associate Professor of Clinical Epidemiology. School of Hygiene, University of Toronto. He is Head, University Clinic for Tropical and Parasitic Diseases, Toronto General Hospital, Toronto.

diagnostic purposes. Immunofluorescence, electron microscopy, new culture media, and laboratory animal inoculates are a new array of diagnostic tools that are valid and reliable only in the hands of well-versed scientific workers.

Tissue responses of a nonspecific nature include: fever, lassitude, splenomegaly, hepatomegaly, cardiomegaly, lymphadenopathy, disturbances of gastrointestinal motility, eosinophilia, hematuria, chyluria, fleeting exanthemata, erythema, macular or papular or pustular eruptions, nodules, and urticarial rashes. They arouse suspicion and become meaningful when history, physical examination, and well-planned laboratory tests are used in corroboration.

#### Patient history #1

A 24-year-old Indian postgraduate student in electrical engineering felt "run down" for six weeks prior to admission. He had never received TAB. His past health included numerous episodes of malaria.

Two weeks before admission to hospital, he had flown to Toronto from northern India. His malaise persisted, and he visited a physician complaining of fever, headache, sore throat, anorexia, malaise, constipation, and a nonproductive cough. He was started on

ampicillin 24 hours prior to admission, but failed to improve and was transfer-

red to hospital.

Physical examination on admission revealed an acutely ill, toxic patient with a temperature of 103°F. His tympanic membranes and his throat were markedly injected. There was no skin rash or splenomegaly. A relative bradycardia was noted at 96/minute, A blood film done on admission revealed malarial parasites, and he was started on a course of chloroquine.

Sixteen blood cultures and one bone marrow culture were positive for S. typhi. Widal agglutination was negative on the second and seventeenth hospital days. On the third hospital day he was started on ampicillin. His hemoglobin was 12.5 Gm/100 ml. and by the seventh hospital day fell to 8.8 Gm./100 ml. with the sudden onset of copious bright red blood and clots per rectum. Massive blood replacement was instituted, and chloramphenicol was substituted for ampicillin.

Over the next 72 hours, 26 units of blood and 2 units of plasma were given. Measured fecal blood loss exceeded 9,000 cc. Calcium gluconate was given periodically intravenously. The platelet count was reduced during the period of maximal blood loss, and several units of fresh whole blood were transfused.

On the eleventh hospital day, the patient's bleeding gradually stopped and did not recur. His temperature, which had continued to be elevated to 105° in a spiking pattern during four days of ampicillin therapy, fell to normal after three days of chloramphenicol. It was never elevated subsequently.

The patient was discharged on the twenty-fifth hospital day. Subsequent follow-up revealed negative stool cultures on all examinations and no further rectal bleeding.

Patient history #2

Ms. M.B., age 23, and Mr. I.W., age 25, served in India for two years as teachers under the sponsorship of CUSO. On their return trip to Canada, they visited friends in Kenya and Ghana

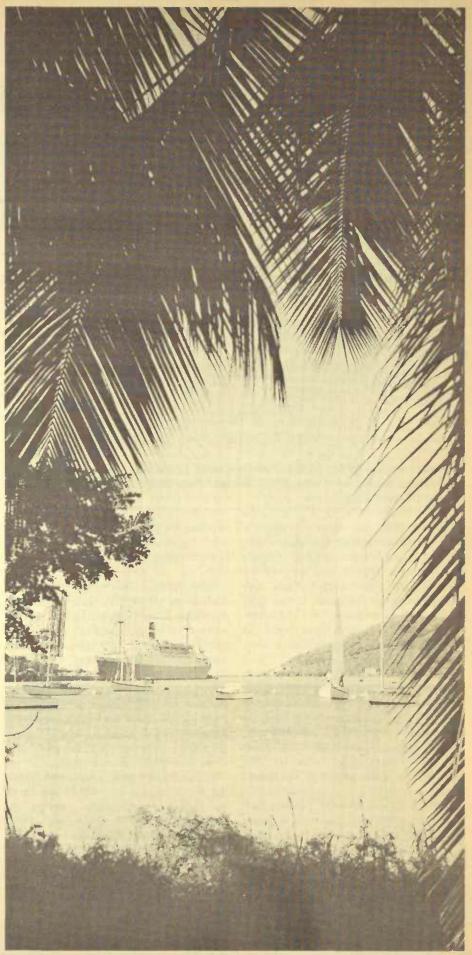


TABLE I

Category of People Served in the Clinic\*

	July- Dec. 1966	1967	1968	1969	1970	1971	Jan June 1972	Total as at 30/6 '72
Immigrants	7	71	185	152	308	570	368	1,661
C.I.D.A.(External Aid)	9	11	25	72	143	170	54	484
C.U.S.O.	25	69	128	190	163	157	45	777
C.1.A.S.P.	_	-	-	54	23	31	6	114
C.E.S.O.	_	_		_		2	_	2
Crossroads Africa	_	1	_	14	18	19	2	54
Operation Tunisia	-	_		_		4		4
Missionaries	89	148	173	195	190	158	62	1,015
Professional								
& Technical Advisers	3	2	44	25	72	100	83	329
Foreign Service						0		
(Diplomats, etc.)	1	6	100	105	1.10	8	1	16
Travelers	14	47	100	127	142	187	124	741
Red Cross			_	_	_		4	4
Residents	2	0	11	10	22	4.0	2.4	126
(non-traveling)	2 5	9 27	32	10	32 17	48	24	136
Foreign Students War Veteran	3	21	32	15	17	22	3	121
(with U.S.M.C.)								1
Visitors & Others			5		4	6		15
U.S. Peace Corps		1	3		4	0		13
U.S. I cace Corps		1						1
								-
	155	392	703	854	1,112	1,483	776	5,475

<sup>\*</sup> Source: Lenczner, M. (1972). The University Clinic for Tropical and Parasitic Diseases: Survey of Community Service. Published by the George Cedric Metcalf Foundation.

for three weeks. During this time, they omitted their antimalarial suppressives.

Two days before leaving Kenya, both became febrile and arrived in Athens with high fever, chills, and general malaise. A doctor, summoned to the airport, suspected a viral infection. Because of the short flight to Canada, they were permitted to proceed with their journey.

On arrival in Toronto, the airport medical officer rushed the patients to the Toronto General Hospital. They arrived in a semicomatose condition, with fever ranging between 103° to 104°F. Blood films revealed the presence of Plasmodium falciparum, and the patients were admitted for treatment.

After a stormy 48-hour period, they improved gradually and had a complete recovery. Since discharge from hospital, they have had no recurrence of malaria.

#### Patient history #3

M.P., a Nigerian immigrant, was referred to the clinic for tropical and parasitic diseases for a routine exam-

ination. No abnormal physical findings were uncovered. Laboratory investigations revealed multiple parasitic infections.

The patient's WBC count was 9,200, with 44 percent cosinophils. Numerous microfilaria of Loa loa (a thread-like worm) were identified in a mid-day peripheral blood film. Ova of Ankylostoma duodenale and Trichuris trichiura, as well as cysts of the protozoan Entamoeba histolytica, were found on stool concentrations. Methods used to detect the ova and cysts were wet mounts and Telemann, M.I.F. (merthiolate-iodine-formaldehyde) and ether-formaline concentrations.

A modified Lawless stain confirmed the identification of cysts of Entamoeba histolytica. Amebic cultures on bivalent media were not helpful. Positive serological tests for amebiasis indicated tissue invasion.

Treatment for loiasis, ankylostomiasis, amebiasis and trichuriasis was instituted. The use of several therapeutic agents required careful assessment regarding their proper sequence, metabolism, toxicity, and side effects.

Summary

Tropical and parasitic diseases present added challenges to health teams in the health units of airports, public health units, university and school health centers, employee clinics, hospital clinics, orphanages, and homes for the retarded and the aged.

Infectious entities are notifiable diseases. Infection occurs by soiled hands with feces, pus, soiled linen, excreta, infected water, or food. Isolation of the patient, his linen, excreta, and utensils is carried out. The use of disposable gloves and proper disinfection must be enforced. Contacts of patients are often difficult to establish.

Rapid intercontinental travel and the increase of people traveling to and from tropical, subtropical, and developing countries have transformed the pattern of medical aspects in our communities. Tropical and parasitic diseases are an additional hazard. To maintain efficiently our high standard of public health and medical care, all members of health teams must acquaint themselves with problems of global medicine.

Bibliography

Lenczner, Michael M. Host — parasite relationship and tissue response in tropical and parasitic diseases. *Int. J. Derm.* 10:2:90-100, Apr./Jun. 1971.

Lenczner, M. and Owen, T. The impact of tropical and parasitic diseases in a non-endemic area. *Canad. Med. Ass. J.* 82:16:805-12, Apr. 16, 1960.

Lenczner, M. Problèmes médicaux des migrants. World Med. J. 11:2:93-4, Mar. 1964.

Lenczner, M., and Holloran, P. Problems in diagnosis and management of typhoid fever and typhoid carriers imported from endemic areas. In International Congress of Infectious Diseases, 5th, Vicnna, 1970. Proceedings. Editors: K.H. Spitzy and H. Radl. Associate editors: F. Potsch et al. Wien Verlag der Wiener Medizinischen Akademic, 1970. vol. 11, p. 67-74.

Lenczner, M. Tropical and parasitic diseases — the impact on our civilization. *Mod. Med. Can.* 22:6:47-57, Jun. 1967.

#### **Precautions for Travelers**

Travel to tropical and subtropical countries can be most enjoyable; however, some attention must be paid to basic measures of health. Although most of the well-known debilitating and serious diseases have been controlled, common sense precautions, simple in practice, must be taken without undue concern and fuss.

In preparing for the trip, consult your physician as to fitness for activities under tropical conditions. A dental review is also recommended. Take along an extra pair of glasses and sunglasses.

Certain immunizations are required by health regulations and certain others are advised, even if not obligatory. As this counsel is usually given by highly trained personnel who are in contact with health authorities of different countries and the World Health Organization, it is wise to follow their recommendations.

#### Preventive measures

Prevention is valuable in the tropics, as public health measures and sanitation cannot be taken for granted. Acquaint yourself with the climate. This knowledge will permit you to equip yourself with the appropriate clothing so you will be comfortable.

Water is often contaminated and therefore a source of intestinal disease. Many establishments provide safely processed water, which may yet be contaminated by dirty hands or unclean containers. Uncarbonated soft drinks are *not* safe. If in doubt, use bottled certified water, or water boiled and cooled in the same container. Chlorination with Halazone or Globaline tablets, used according to instructions, makes water safe.

Milk is rarely pasteurized, and therefore must be boiled.

Water for bathing should come from a treated source. Salt water bathing is safe, if the beaches are not contaminated by fresh-water streams or sewage outlets. In some regions, fresh water streams, marshes, and rice paddies are sources of serious illness. Swimming in artificial pools should be followed by shower and proper drying of skin to avoid fungal infections.

Food is easily contaminated by water, unclean hands, containers, and unhealthy food handlers. The contamination is the source of simple diarrheas, food poisoning, and more serious conditions. Remember, food inspection, refrigeration, and health rules are not to be taken for granted in tropical and underdeveloped countries.

The following rules should be observed: Eat no raw fruit or vegetable unless it has an unbroken skin, has been well washed with safe water, and peeled by you. Boil or bake all other fruit or vegetables.

Don't be tempted by fancy dishes or uncooked pork or meat with palatable seasoning or sauces, when you are in apparently luxurious surroundings that are of unknown hygiene. It is preferable to have hard-boiled eggs in the shell, dry biscuits from a tin, and tea, than a tasty, unknown dish of doubtful hygiene. Avoid raw bacon and ham and meat that has been insufficiently cooked.

#### Insects

Mosquitoes, sandflies, fleas, ticks, mites, lice, gnats, and killer bugs are not only a great nuisance, but are also carriers of serious diseases. They abound around primitive dwellings

with unhealthy surroundings, stagnating waters, and lack of sewage disposal. Spray rooms with DDT or other insect aerosols and bear the smell of the chemical, rather than open windows, especially when you have the lights on.

Mosquito nets and repellants are important after sunset. Preventive antimalarial medication, such as chloroquine, or any other medication, should be taken only on advice of a physician.

Beware of stray dogs, cats, and pets, such as friendly, tame monkeys. Rabies and lockjaw (tetanus) are still quite frequent in some tropical and subtropical zones.

When arranging jungle excursions or hunting trips, even those that are well guided, make sure about the proper clothing, high-strapped boots, repellants, and mosquito nets.

Poisonous snakes don't usually attack unless stepped on or threatened. High boots are a good protection. A snake-bite kit containing antivenom has saved many a life.

Never bathe in unknown waters! Sharks, barracuda, jelly fish and, at times, poisonous snakes are a real danger. The natives are aware of these dangers, and an inquiry may help you avoid them.

In general, moderation in eating and drinking, proper rest, and commonsense rules are applicable in the tropics as well as at home. Seek advice and proper medical care, if required.

## idea exchange



#### Hold a fair, stock a cart: for inservice education

Ann Frances Allen

The monthly "fair"

In a busy teaching hospital, finding ways to demonstrate new nursing techniques and equipment to all statt is a constant challenge. One method we have found stimulating and successful is a monthly "Fair" presented by the staff of specialty units, such as cardiovascular surgery, urology, neurology, orthopedics, ambulatory services, and the neonatal unit.

The fairs are one-day displays posters, mannequins, slides, films with opportunities for questions and answers, and open discussion. They are held in an area away from the ward, and medical and paramedical personnel are invited to drop in between 9:00 A.M. and 4:00 P.M.

The information presented at a

"Growth and Development" fair, with

pictures of the displays, has now been put into manual form. It is available to the wards as well as to individuals who may wish to purchase one.

The "Fair" has proven to be an excellent learning experience for coordinators and visitors alike.

**Teaching cart** 

Keeping abreast of the times professionally is often difficult for the busy nurse, whose time and energy is spent answering the needs of her patients. To facilitate reading on the ward during precious "spare moments," the inservice education nursing personnel created a "Teaching Cart.

The cart, a podium-type box on wheels, contains a tape recorder and tapes, 20 to 30 professional articles, and a book for staff comments. The articles are enclosed separately in clearly labeled, numbered folders. A numbered index of articles and a list of the subjects on tape are firmly attached to the top shelf of the cart. A monthly circulation schedule allows each ward to have the cart for three or four days

The articles are copied from nursing and medical journals, and the tapes are recorded when special speakers

discuss pertinent subjects.

Members of the inservice staff select the topics, based on the needs and interests of the ward nurses and on suggestions or requests from the nursing staff. One member of the inservice staff is responsible for the cart — setting up new material, reviewing, arranging monthly schedules, finding misplaced articles, and keeping the cart in order.

Recently, an evaluation survey indicated the staff wished the cart to remain longer on their wards. Consequently, another cart will be set up to allow it to stay at least a week in each ward.

The author is assistant director of nursing education at The Montreal Children's Hospital, Montreal, Quebec.

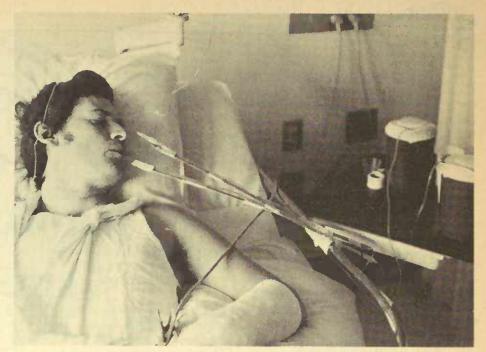
38 THE CANADIAN NURSE

#### Drink up a tune

Recently, while our hospital had a patient whose injury denied him the use of both his hands, one of our practical nurses devised a "gimmick" to allow him to drink on his own:

'Take a set of IV tubing (we use Abbott) and cut off the drip chamber. The latter can be taped to the end to serve as a weight. Then strap the tubing to a succession of taped tongue depressors, long enough to reach from the water or juice jug to the patient's mouth. The extension of tongue depressors is taped to the raised side rail of the bed at an angle of 25 degrees to prevent backflow.

The patient drinks from the end that is usually hooked to the needle, the other end being weighted and submerged in a jug of fluid. If more than one jug is set up, the patient may "drink up a tune." — The author, Gillian Holland, is nursing supervisor at the Penticton Regional Hospital in Penticton, British Columbia.



#### Preadmission patient teaching clinic

The Montreal General Hospital began its biweekly preadmission patient teaching clinic in November 1972, to provide information to groups of elective patients about to have similar abdomin-

The stimulus for group teaching resulted from a change in administrative policy. Pretesting of patients commenced a year ago to shorten the preoperative period and thereby mobilize more bed space.

Patients come to the hospital for routine tests two weeks before surgery. Test results are sent to the unit on the patient's admission day, which is the afternoon before surgery.

The patient is thus placed in a "future shock" situation where, in an unfamiliar environment, many things happen to him in a brief period. The nursing staff also has less time to prepare the patient for the crisis of surgery. The result is that patients are fearful postoperatively and therefore reluctant to carry out those activities beneficial to their recovery.

To rectify this situation and thereby ensure adequate preparation for surgery, our teaching clinic emerged. Its specific aims are to initiate personal contact with the patient, to acquaint the patient with the purpose and nature of activities carried out pre- and postoperatively in any type of surgery, to provide an opportunity for questioning, to offer the advantages of group learning, to meet individually with those patients who demonstrate further need, and to allow nurses on the surgical units more opportunity to focus on

the individual patient.

In cooperation with the admitting department, the clinic nurse contacts the patients by telephone and invites them to attend the class on the pretesting day. Screening occurs at this time. For example, an overly anxious person, who may not be suitable for the group, may need to be seen individually by the nurse.

Anyone with a special concern can see the nurse alone, after the group session, while waiting for a blood test or x-ray. Each patient is aware that any information he gives to the nurse is made available to the staff through the nursing care plan that is begun for each individual. This plan is examined during the meeting so that patients are familiar with the type of questions to be asked during the nursing interview on admission to the unit.

Since the clinic has come into existence, the staff can focus on the individual needs of a patient, and time normally spent introducing material to him can now be spent assessing his comprehension and his concerns, some of which may already be indicated on the care

The written instructions given to the patient in the clinic are reinforced by the staff. Postoperatively, the staff

encourage and assist the patient to carry out the necessary activities; a patient in pain may be refuetant to be active, even if he knows this is necessary to his recovery.

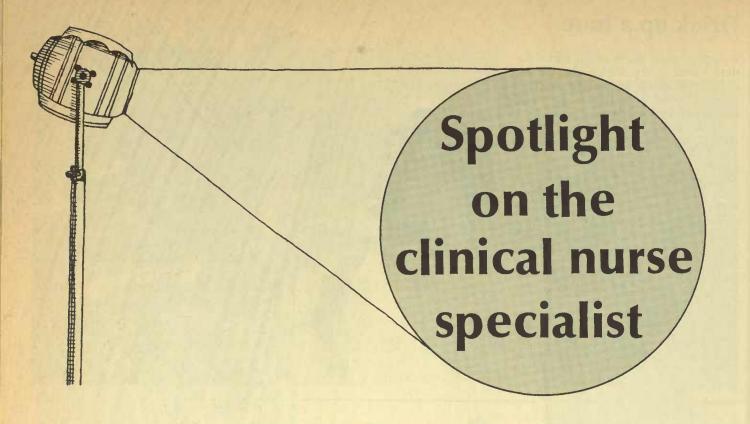
To determine whether patients benefit from the contact, a follow-up is made of selected patients. The data gathered at this time show that patients remember the activities taught them and, in most cases, initiate them after

surgery.

Patients have responded positively to our clinic, indicated by their attendance and their written comments on the questionnaires completed after discharge from hospital. The general reaction is lowered anxiety and a sense of control over the environment. "I know what to expect, which eases my mind," is the usual comment. A factor that may lower anxiety is timing, as patients have two weeks to get used to what will happen in hospital.

The positive value of the clinic to the patient, and his consequent behavior after surgery, have led us to extend our program to other groups of surgical patients. — Carol McCone is coordinator, preoperative teaching clinic at The Montreal General Hospital, Mont-

real, Quebec.



At a conference in Toronto last June, the newly emerging role of the master's-prepared clinical nurse specialist was examined. The conference, sponsored by the University of Toronto faculties of nursing and medicine and the school of hygiene, made one thing clear: the role of this nurse specialist is not clearly defined or understood.

#### **Carol Dworkin**

Nurses, physicians, hospital administrators, and educators have different ideas about the clinical nurse specialist. They do not all agree on the combination of formal education and clinical experience she requires, the extent of her role, or the advantages she offers patients and staff. Even the term itself bothers some.

On the first morning of a Toronto conference on the clinical nurse specialist, clinical nurses who have had experience in various specialty areas interpreted the role of the master'sprepared clinical nurse specialist as they see it. This formed a good basis for discussion. The conference report that follows highlights the work clinical nurse specialists are doing in the United States and Canada.

Ms. Dworkin, a graduate of Carleton University School of Journalism, Ottawa, is editorial assistant, The Canadian Nurse.

THE CLINICAL NURSE specialist is doing no more nor less than nurse practitioners should have been doing since Florence Nightingale. Every beginning nurse practitioner should be a budding clinical nurse specialist." — Laura L. Simms, R.N., B.A., Ed.D.

Dr. Simms spoke from her experience as clinical department head, surgical nursing, at The New York-Cornell University Hospital. She is also an associate professor in the Cornell University School of Nursing and a consultant to the Surgeon General of the United

The term "clinical nurse specialist," she noted, was first used in the United States in 1938, although programs were not begun until a decade later. She said this term refers to a nurse with advanced competence who is primarily responsible for nursing practice.

According to Dr. Simms, the clinical nurse specialist at the New York Hos-

SEPTEMBER 1973

pital is completely removed from the nursing hierarchy; moves freely in the hospital organization, reporting to the nursing office; is free to be a representative of the patient's interests; is responsible for a group of patients on a 24-hour basis; and decides the nursing activities that can be done by others. She bases her decisions on her diagnosis of the patient.

In reality, the clinical nurse specialist is too often ignored or rejected because her "expert clinical experience is not readily perceived," Dr. Simms said. For this reason, she must have active administrative support from the nursing office. Although her primary responsibility is to specific patients, supervision, teaching, coordination, and research are inherent in her role.

Dr. Simms explained that clinical nurse specialists were first used at the 1,000-bed New York Hospital in 1963 to provide comprehensive patient-centered nursing care for open-heart surgical patients. The plan called for nurses engaged in independent practice. This new position, she said, meant a complete break. "To superimpose the nurse specialist role on the general staff nurse role would defeat the purpose."

There are now 26 clinical nurse specialists at the New York Hospital. In the surgical nursing department, a clinical specialist works in the children's urology unit with the young patients and their families, who are learning to cope with an 'ostomy. This specialist's practice was so demanding that a second member had to be added to her staff, Dr. Simms remarked.

The clinical specialist's work in the children's urology unit includes taking care of patients referred by physicians, who often look to the clinical specialist to find the best location for the stoma; prescribing medication and appliances; and conducting classes for parents and telephoning them after their child is discharged.

There is also a clinical specialist in the clinical nursing department who, has a background in surgical nursing and care of children, another who works with mastectomy patients, and a clinical specialist in mental health who works throughout the hospital.

Dr. Simms spoke of the most recent project, scheduled to begin last July, SEPTEMBER 1973

in which nurses on a unit are completely responsible for handling patients' physical and emotional responses to surgery. A physician will always be on call, she added.

"What we have done could not have been accomplished without the cooperation of surgeons," she said. She also noted that the use of clinical nurse specialists has not meant additional staff members. The traditional supervisors have been allowed to "gradually fade away." Dr. Simms was critical of supervisors who make rounds but do not do anything with the information they collect.

"This is not an extension of the physician," Dr. Simms said in referring to the role of the clinical nurse specialist. She explained it means nurses are adding a new dimension; for example, nurses will decide whether a patient needs an IV. "If we do not add this new dimension, we might as well forget we exist," she said.

WITH THE INCREASING complexity of health problems... and the seemingly greater number of multiproblem families in the public health nurse's caseloads, the master's-prepared clinical practitioner with a specialty in public health nursing has a definite role in today's health care system."— Caroline Snyder, R.N., B.Sc. N., M.P.H.

As a public health nurse clinician recently employed by the Visiting Nurse Association (VNA) of Cleveland, Ohio, Caroline Snyder was the leader of a team that consisted of baccalaureate and diploma nurses and licensed practical nurses. She called this "an excellent opportunity to serve as a role model.'

As well as providing comprehensive nursing care to patients and their families. Ms. Snyder found she served as a consultant on an informal basis. When other nurses required assistance with particular problems they had in handling their cases, she often helped them understand the dynamics of their families' problems, work out possible approaches to solving the problems, and formulate goals and nursing care plans. On some occasions, Ms. Snyder made joint home visits with team members to demonstrate certain nursing procedures. She explained that the two most common ways in which she served as a role model were by having the staff nurses read her narrative reports of home visits and by discussing family cases with them. "These efforts seemed to increase team members' awareness of the dynamics of family interaction and their relationship to the total situation," she said.

She quickly realized certain nurses developed specialized skills because of their experiences and interests, and used these nurses as resource persons when specific problems arose. She made use of conferences with the district director, under whom she worked, to explore the theoretical bases for nursing actions and to set priorities in her caseloads. (Half of her caseload of more than 40 patients required comprehensive care.)

Ms. Snyder said she made frequent contacts with professionals of various disciplines to coordinate efforts to assist particular families. She also arranged interdisciplinary conferences to make certain all those actively involved in a family's care had common goals and plans for action.

The nurse clinicians, she added, presented comprehensive cases monthly at a meeting led by a psychiatrist and attended by the entire administrative staff; theory was reviewed in depth and nursing care plans were developed.

As a public health nurse clinician, she became involved with the community in which she worked. One example of this was a "nurse clinic" she had established in a high-rise apartment for the elderly. She met with the residents weekly for consultation and referral. After she obtained histories, residents were referred back to their private doctors, admitted to the VNA for nursing service, referred to the local hospital's outpatient department for follow-up care, or referred to other community health and welfare agencies. She also helped arrange health educational programs for the elderly.

The patient load at the local hospital's outpatient department increased nearly 100 percent as a result of her referrals, she pointed out.

As part of her community involvement, Ms. Snyder worked at the community center in her geographic area. Once a week she took walk-in referrals,

and on other days took referrals made by telephone to the VNA office. She judged whether the referral was appropriate for that agency or whether another service was needed.

She attended staff meetings at the community center to interpret her agency's services to other professionals and inquire whether they could assist the VNA with certain social problems. Through her contact with this center, she became involved with a community project to open a community health center. And this led to working to attack the drug problem.

While she was with the VNA, she held a clinical instructor position with Case Western Reserve University. Undergraduate and graduate public health nursing students accompanied her on home visits to learn about the agency and the clinician's role.

Because clinicians do not want to get "stale," Ms. Snyder said they continually need intellectual stimulation at their level of functioning. She pointed to the need for inservice education programs for them or attendance at workshops or university classes.

Ms. Snyder found her two years with the VNA challenging, and said her role was accepted by the agency and community. "Above all else, patients, their families, and the community at large benefit from the services of a public health nurse clinician," she said.

NURSING IS HELPING people to live, not just to stay alive. If you can't live the way you want to, why bother? You must enjoy it." — Joanne Lagerson, R.N., M.A., A.R.I.T.

With the help of slides, Joanne Lagerson discussed the work she does as clinical specialist in respiratory care at St. Vincent's Hospital and Medical Center of New York.

She set the tone for her presentation by telling the audience the word "bed" comes from the Welsh "bedd," meaning "grave." She then showed slides of patients in bed, and questioned whether some patients were in bed for staff convenience.

As a clinical specialist, she is a con-

sultant to nurses on all units, including pediatrics. Flexibility of time is most important to her. She said she tries not to do anything she can get another nurse

"One of our most important obligations is to teach," Ms. Lagerson said. Criticizing the small amount of time spent on prevention, she asked: "What happens to the patient when he leaves the intensive care unit? Who sees him again?" She added that most postoperative complications can be prevented. "Too many patients go to surgery without preoperative instruction. That is manslaughter."

Her work with staff includes giving lectures on respiratory care in July and August. She emphasized that she gives these lectures to nurses and physicians together. Noting the separation between these two groups, she remarked, "In our hospital, we have a separate cafeteria for physicians!"

"THERE IS NO ONE, clearly defined role for the clinical nurse specialist." — Olga Darcovich, B.Sc.N., M.A.

Describing her work as a clinical nurse specialist in psychiatric nursing at McMaster University Medical Center in Hamilton, Ontario, Olga Darcovich said it was difficult for her to interpret her role because of the problem of making herself visible. She does not usually wear a uniform, and spends much of her time with staff.

Working in the psychosocial program in the hospital, she is responsible for ensuring that behavioral concepts are integrated into everyday care. Her focus is on nurse members on the clinical team.

In her role as a clinical nurse specialist, she gives direct patient care and develops psychosocial skills through education. She provides consultation, acts as a role model, does informal teaching, and provides formal staff development and inservice orientation.

Teaching is the major function for a person in her role, she said. The educational component sometimes involves the identification and intervention of organizational problems. She gave as an example poor communication among team members. If nurses do not have the information they need, they sometimes require extra support, she explained.

Following the June conference, Ms. Darcovich gave her observations of the meeting:

"The discussions reinforced my previous observation that there was no one clearly defined role for the clinical nurse specialist. Rather, there seem to be at least two streams of development — one primarily involving direct patient care with a select patient population, and the other primarily involving staff education.

"The other issue arising out of the seminar is whether the label 'clinical nurse specialist' identifies a role or whether it identifies a master's-prepared

"Several seminar participants noted the need to evaluate the contribution of clinical specialists to health care. I endorse this recommendation and would like to learn of evaluative studies. either completed or in progress, in Canada. We don't have a study underway at McMaster at present," she said.

## dates

#### September 28-30, 1973

Canadian Society of Extra-corporeal Circulation Technicians, sixth annual meeting, Holiday Inn, Ste Foy, Quebec. Exams for certification (members only) will be held September 27. All dialysis and heart-lung perfusionists welcome. For further information, write to: Can-SECT, Box 7317, Ottawa, Ont. K1L 8E4.

October 1-3, 1973

Association of Canadian Medical Colleges, Association of Canadian Teaching Hospitals, Canadian Association of University Schools of Nursing, annual meeting, McMaster University Health Sciences Centre, Hamilton, Ontario. Theme: "Coordination and Integration of Health Sciences Education, Health Services and Health Research." Fee: \$25. For further information, write to: ACMC/AFMC, 151 Slater St., Ottawa, Ont. K1P 5H3.

#### October 1-3, 1973

Nurses' Association of the American College of Obstetrics and Gynecology (NAACOG), District I Convention, Chateau Halifax, Scotia Square, Halifax, N.S. Theme: "Portrait of the Female — Patient or Person."

#### October 1-3, 1973

Association of Registered Nurses of Newfoundland, annual meeting, St. John's, Newfoundland.

#### October 11-12, 1973

Conference on "The Future Role of the State Hospital," sponsored by the Division of Community Psychiatry, State University of New York at Buffalo. Psychiatrists, psychologists, social workers and therapists are invited to attend. Fee: \$50. Address inquiries to: Berna Koren, Div. of Community Psychiatry, 462 Grider St., Buffalo, N.Y. 14215, U.S.A.

#### October 13, 1973

Health team conference on "The Art of Understanding: Care and Caring SEPTEMBER 1973

for the Patient with Cancer" sponsored by the University of Ottawa School of Nursing and the Canadian Cancer Society, Marion Hall Auditorium, U. of Ottawa. Registration fee: \$5.00. For further information, write to: Marie A. Loyer, School of Nursing, U. of Ottawa, 770 King Edward Avenue, Ottawa, Ontario.

#### October 16, 1973

Workshop on tuberculosis and respiratory disease, sponsored by the New Brunswick Tuberculosis and Respiratory Disease Association, Nurses' Residence, Hotel Dieu Hospital, Tracadie, N.B. No registration fee. Program to be conducted in French. For further information, write to: A.H. Gardner, Executive Director, N.B. Tuberculosis and Respiratory Disease Association, Box 1345, Fredericton, N.B.

#### October 19, 1973

One-day workshop on "Power: The Powerful and Powerless in Health Care Systems," presented by the McGill University Psychiatric Nursing Conference, Sheraton Mount Royal Hotel, Montreal, Quebec. Fee: \$10.00. Nurses, medical and paramedical staff are invited to attend. For further information, write to: Ms. Evelyn Malowany, 4590 Prince of Wales, NDG, Montreal, Quebec.

#### October 22, 1973

Symposium on "New Horizons in the Care of Patients with Cardiorespiratory Disease" for nurses and allied health professionals, Four Seasons Hotel, Toronto. Fee: \$35. A number of workshops are planned to identify patient therapy needs. For more information, write to: American College of Chest Physicians, P.O. Box 93826, Chicago, Illinois 60690, U.S.A.

#### October 24-25, 1973

International symposium on gonorrhea sponsored by the Health Protection Branch, Health and Welfare Canada,

Ottawa. Registration fee: \$40.00 Simultaneous translation available. For further information, write to: Ms. Jean R. Renaud, Head, Technical Secretariat, Health Protection Branch, Tunney's Pasture, Ottawa, Ontario K1A 0L2.

#### October 24-26, 1973

Alberta Hospital Association, annual convention, Jubilee Auditorium, Calgary, Alberta.

#### October 29-31, 1973

Ontario Hospital Association, annual meeting, Four Seasons Sheraton Hotel, Toronto, Ontario.

#### November 5-7, 1973

Association of Nurses of the Province of Quebec, annual meeting, Montreal, Quebec.

#### November 6-9, 1974

The Nurses' Association of The American College of Obstetricians and Gynecologists, Ontario District V, conference, Royal York Hotel, Toronto, Ont.

#### November 13-14, 1973

Maritime Operating Room Nurses Convention, Hotel Nova Scotian, Halifax, Nova Scotia. Direct enquiries to: Ms. Mary S. Shinney, Apt. 3, 5240 Kent St., Halifax, N.S.

#### November 28-30, 1973

Manitoba Health Organization and incorporated sixth annual Manitoba health conference, Centennial Concert Hall, Winnipeg, Manitoba.

#### June 16-21, 1974

Canadian Nurses' Association annual meeting and convention, to be held in the Manitoba Centennial Centre Concert Hall, Winnipeg, Manitoba.



### names

#### Five Saskatchewan Nurses Honored



Honorary membership in the Saskatchewan Registered Nurses' Association was conferred on five retired nurses at the association's annual meeting held in Yorkton in June. Proudly displaying their certificates are, *left to right*, Esther Paul of Preeceville, Alice Schwartz of Regina, Ellen Auckland of Melville, Ann Heffel of Regina, and Laura Clarke of Rosetown. On the extreme right is Jean Pipher of Saskatoon, president of the SRNA.



Rachel Lamothe has left the Canadian Nurses' Association, where she has been a research consultant, to teach nursing subjects at the CEGEP in Three Rivers, Ouebec.

This is to prepare herself for her appointment as director of the nursing option at the bilingual CEGEP in St. Lambert, Quebec, a post she assumes in January, 1974.

Anne Hanna (B.J., Carleton University, Ottawa) has recently joined the staff of the Canadian Nurses' Association as writer-editor.

Her major writing, research, and editing experience has been in the areas of poverty and criminology. Prior to her

recent association with the Centre of Criminology at the University of Ottawa as research editor, Ms. Hanna was assistant editor for the Report of the Special Senate Committee on Poverty, under Senator David Croll. She wrote A History of The Canadian Centenary Council.

Ms. Hanna has three school-aged children, and lists her outside interests as skiing, swimming, and attending theater productions.

During the June annual meeting of the Saskatchewan Registered Nurses' Association in Yorkton, the following new members were elected to council: president-elect: Jane MacKay, nursing consultant, provincial department of health, Regina; first vice-president: Sister Bernadette Bezaire, director of nursing, St. Paul's Hospital, Saskatoon; chair-

man of social and economic welfare committee: Grace Hutchinson, assistant head nurse, Grey Nuns (Pasqua) Hospital, Regina; and chairman of the chapters and public relations committee: Rita Ledingham of Saskatoon, a former coordinator, Saskatchewan Institute of Applied Arts and Sciences.

Dr. Bette M. Stephenson, new president of the Canadian Medical Association, is the first woman to hold that post in the association's 106 year history. Dr. Stephenson, currently on staff of the North York General Hospital in Toronto, was chairman of the CMA's board of directors during the past year and a former president of the Ontario Medical Association.

Margaret D. McLean has resigned as senior nursing consultant, hospital insurance and diagnostic services, Health and Welfare Canada, to accept an appointment as director of the school of nursing, Memorial University, St. John's Newfoundland. She succeeds Joyce Nevitt who has been director of the school since its founding in 1966, and who is on sabbatical leave.







Joyce Nevitt

Ms. McLean (R.N., Royal Victoria Hospital School of Nursing, Montreal; B.Sc.N., U. of Western Ontario, London; A.M., Columbia U., New York) served with the Royal Canadian Navy during World War II, has been associate professor of nursing education at the University of Western Ontario school of nursing, and nursing consultant with Gordon Friesen Associates.

Active in professional associations, Ms. McLean has been on the executive of the registered nursing associations of Alberta and Ontario, and was second vice-president of the Canadian Nurses'

Association (1968-70).

SEPTEMBER 1973



Elizabeth McCue, who has been nursing consultant in mental health, Health and Welfare Canada, since 1964 has just retired from that position. She will continue to live in Ottawa and hopes

to find time to resume her many hobbies, gardening for one.

Lois E. Graham was appointed dean of nursing at the University of New Brunswick, for a five-year term beginning July 1.

She succeeds Margaret G. McPhedran who has been dean for five years. Professor McPhedran will remain at the university as a teaching member of the

faculty.





Lois Graham

MargaretMcPhedran

Dr. Graham (R.N., New England Memorial Hospital, Stoneham, Mass.; B.Sc.N.E., Walla Walla College, Washington State; M.A., and Ph.D., U. of Michigan) originally from Harvey, New Brunswick, has worked extensively in the United States: at Columbia Union College in Maryland as associate professor of nursing and program director; at Catholic University of America in Washington, D.C., as assistant professor of nursing; and at Southern Missionary College in Collegedale, Tennessee, as curriculum consultant.

Dr. Graham has had articles published in the American Journal of Nursing, the Journal of Nursing Education, and Nursing Research.

Aleen McPhee, public health nurse, has been appointed coordinator of the nursing care project instituted in Vernon, British Columbia. The project will operate from 0800 hours to 2000 hours seven days a week, to provide nursing care services as well as drugs, dressings, and similar items free of charge. Meals on wheels and homemakers are provided when needed.

The project is intended to ease pressure on acute care hospital beds, and to speed recovery of the patient in his own home, without decreasing quality of care received.

**SEPTEMBER 1973** 

Ninety-two years of public service had been devoted to public health nursing by Frances French, Dorothy Hart, and Margaret Smith when they were honored at a dinner on June 8th on the occasion of their retirement from the Middlesex-London District Health





Frances French

Dorothy Hart

Ms. French (Reg.N., Victoria Hospital school of nursing, London; B.Sc.N., University of Western Ontario) joined the London Health Department in 1938, and was for many years the nurse-in-charge at the vene-

real disease clinic at Victoria Hospital. Ms. Hart (R.N., Grace Hospital school of nursing, Detroit; Dipl. PHN, University of Western Ontario) has made her career as a nurse with the London Health Department, except for a two-year stint with the Ontario Society for Crippled Children. Her special interest has been the department's pre- and perinatal program.

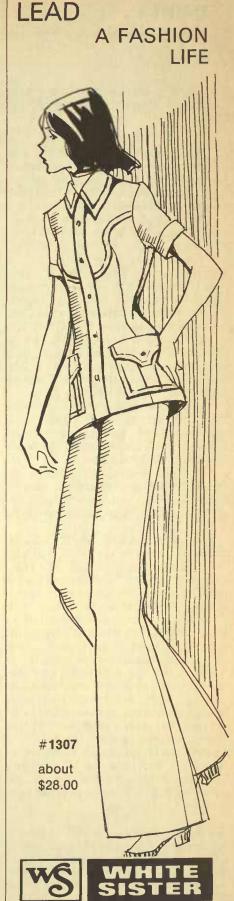


Ms. Smith (Reg.N., Toronto General Hospital school of nursing; Dipl. PHN, University of Toronto) worked with the City of Toronto Health Department prior to serving overseas during

World War II with the Royal Canadian Medical Corps. Shortly after her return to Canada, Ms. Smith joined the Mid-dlesex County school health services which later was melded into the Middlesex-London District Health Unit.

Jennie E. Ives, since 1968 senior nursing consultant, nursing services, of the Ontario Health Insurance Plan (formerly Ontario Hospital Services Commission) has recently retired.

Ms. Ives (Reg.N., Belleville General Hospital School of Nursing; B.Sc.N., Columbia U., New York) worked in many Ontario centers, including Belleville, Collingwood, and Fort William, before joining the staff of the Toronto General Hospital, where she became assistant superintendent of nurses. Just prior to her appointment as nursing consultant with the Ontario Hospital Services Commission in 1959, Ms. Ives



#### names

was nursing service secretary of the Registered Nurses' Association of Ontario.

A merit award for continuous high quality nursing service was conferred on Catherine W. Keith, nursing officer, staff development, medical services branch, Health and Welfare Canada.

Ms. Keith (Reg.N., Soldiers Memorial Hospital, Campbellton, N.B.; B.N., McGill U.; M.S., C.N.M., Columbia U., New York) since her nursing service with the armed forces during World War II, has devoted most of her nursing career to Canada's northern peoples. She has been an outpost nurse in Quebec with the Canadian Red Cross Services; staff nurse and later, matron, at Moose Factory Indian Hospital; field and regional nursing officer in the northern Alberta area of the Foothills region and in the MacKenzie Zone.

Having joined the Indian and Northern Health Services in 1950, Ms. Keith had a wealth of experience to draw on when in 1969 she accepted the head-quarters position she now holds.

Ms. Keith, when receiving her award, regretted that her colleagues, nursing and otherwise, who contributed so much could not be present to share the

She spoke not only of the achievements of nurses in the north, but also those of their support staff. She especially commended the native auxiliaries (nursing assistants, community health workers, and caretakers) adding, "It is a source of personal satisfaction to know that opportunities are becoming greater for them to develop their po-

tential and contribute even more.'

Ms. Keith, in reiterating that this merit award recognizes achievement in nursing, particularly with the public service, gave credit to those nurses who are not full-time public servants but who contribute greatly to the total service: nurses of remote religious institutions, and wives of Hudson Bay Company employees, Royal Canadian Mounted Police, and school principals.

Sister Mary MacLeod has been appointed director of St. Rita Hospital School of Nursing, Sydney, Nova Scotia, replacing Sister Mary MacIntosh, superior-general elect of the Sisters of St. Martha's, Antigonish.

Sr. MacLeod (R.N., St. Joseph's School of Nursing, Glace Bay; B.Sc.N.,



Catherine Keith, nursing officer staff development, medical services, Department of National Health and Welfare, talking to her one-time colleague Dr. Percy Moore, former director general, medical services. Dr. M.L. Webb, assistant deputy minister, medical services, looks on. Ms. Keith was awarded a certificate of merit and a cheque for her long and distinguished service to the branch.

U. of Western Ontario; M.Sc.N., U. of Boston) has, for the past two years, been on the nursing faculty of St. Francis Xavier University, Antigonish, Nova Scotia.

Jeanne Reynolds has been appointed dean of the faculty of nursing of the University of Montreal. She succeeds Alice Girard, on her retirement. Dr. Girard has been dean since the inception of the faculty in 1962.



Jeanne Reynolds



Alice Girard

Dr. Reynolds (B.Sc.Ed.Inf., U. of Montreal; M.Ed., and Ph.D., U. of Ottawa) has been instructor at Sacré-Coeur Hospital in Cartierville and the Margaret d'Youville Institute; assistant director of the school of nursing, Maisonneuve Hospital; and director of the school of nursing, then director of St-

Luc Hospital in Montreal prior to becoming vice-dean of the faculty of nursing, University of Montreal.

Active in professional circles, Dr. Reynolds has also published several articles on nursing.



E.E. "Jamie" Jameson has recently retired as director of nursing education of the Calgary General Hospital. Ms. Jameson (R.N. Calgary General Hospital school of nursing; B.Sc.N., U.

of Minnesota; M.N., U. of Washington) was in charge of the nursery and taught nursing arts and medical and obstetrical nursing at the Calgary General Hospital before becoming director of education in 1961. She has held many offices in the Alberta Association of Registered Nurses and has been a member of the nursing education committee of the Universities Co-ordinating Council.

Ms. Jameson plans to write a history of the school of nursing of the hospital she has served so well and will now have time for her hobbies of gardening

and photography.

SEPTEMBER 1973

## for relief of postpartum discomforts only Tucks babies tender tissues two ways

as a soothing wipe...as a cooling compress...and as often as she likes

Tucks medicated pads give your postpartum patient more relief, more often than ointments or aerosols because pads can be used more ways. Cooling Tucks medication can be applied by using the pad as a compress. Or the pad can be used as a wipe to both soothe and cleanse. As a wipe, it lets her avoid the mechanical irritation of harsh, dry toilet paper. A Tucks pad under her sanitary pad prevents chafing too.

Tucks medication gives prompt, temporary relief from postpartum discomforts—the itching, burning and irritation of episiotomies and simple hemorrhoids. Its active ingredients are witch hazel and glycerine-there is no "caine" type anesthetic

in it. Your patient can have her own supply of Tucks at bedside for self-administered relief with minimum risk of over-treatment or sensitization.

In addition, Tucks medication is buffered to an approximate pH of 4.6. This helps tissues maintain their normal acid defenses. Prescribe Tucks pads at bedside for soothing, cooling comfort from the first postpartum day on.

Order a trial supply on your Rx. Write to:



## research abstracts

Riddell, Beverley, J. A multidimensional analysis of role perception in a mental health system. Calgary, Alberta, 1971. Thesis (M.Sc.) U. of Calgary.

A review of the literature indicates a lack of clarity and consensus of role definitions within the field of mental health. The present research was directed toward an investigation of role perceptions among social workers, psychiatrists, nonpatients, psychiatric nurses, orderlies, psychologists, occupational therapists, nurses, patients,

and general practitioners.

Subjects in each of the groups mentioned above were requested to judge perceived similarity between each role and every other role. The concept *myself* was included in the stimulus judgments to indicate the degree of inter- and intra-position consensus. A multidimensional successive intervals scaling analysis was conducted on the judgments of each group. Results were examined with respect to the dimensions obtained within and between all groups.

Results indicated a differentiation of judgments between the respective occupational role and *myself* for social workers, psychiatric nurses, nurses, and psychiatrists. Other dimensions held in common by a number of groups were labeled as: ancillary services, psychiatric care, medical care giving, frequency of patient contact, activity orientation, and so on. Unique dimensions also occurred for some groups.

The implications of these results were discussed within the framework of role theory. Consideration was also directed toward the clarity and consensus of the obtained dimensions.

McEwan, Ada E. A study of the attitudes of public health nurses as they affect the teaching of family planning. Chapel Hill, N.C., 1972. Major paper (M.S.P.H.) U. of North Carolina.

The purpose of this study was to determine what factors, if any, affect the attitudes of public health nurses in integrating family planning information into their regular teaching program. The study was carried out in seven

urban-rural health units in the province of Ontario that sponsored or co-sponsored a family planning clinic.

Related literature was reviewed and a questionnaire designed for the purpose of quantifying attitudes and dividing them into positive and negative values. The questionnaires were administered by mail. The relationship between a number of independent variables and the dependent variable, nurses' attitudes, was analyzed.

The results of the study indicated that age, religion, frequency of patients' requests, and the method of introduction by the nurse were related

to attitudes.

Continuing research should be carried out and educational programs evolved to assist nurses in developing more positive attitudes. If family planning information and services are to be made available to all those who need them, nurses' themselves will require more understanding of the factors that interfere with their ability to incorporate family planning into their regular teaching program.

Skelton, Judith M. An experimental study to evaluate the effectiveness of a diabetic teaching tool. Vancouver, B.C. 1973. Thesis (M.S.N.) U. of British Columbia.

The purpose of this study was to answer the question: "Will diabetic patients taught by means of a 'diabetic teaching tool' demonstrate a higher tevel of learning about self-care, than patients taught in the institution's usual manner?"

The answer to the question was sought by comparing the self-care knowledge and skills of two groups of diabetic patients admitted to a suburban general hospital which, prior to the study, offered no planned program of diabetic patient education.

All diabetic patients admitted to this hospital over a six-month period were screened for eligibility to participate in the study according to criteria stated by the researcher. Eligible patients admitted in the first three months were designated as control subjects; those in the last three months were designated as experimental subjects. The 20

subjects in the control group were taught in an unplanned manner, based on whether and/or what instructions were deemed pertinent by their nurses.

A "diabetic teaching tool" — designed by the researcher and administered by each patient's own nurse(s) — was used to instruct the 20 experimental subjects. After discharge, each of the 40 subjects was visited by the researcher, at which time a profile sheet was completed and a test of diabetic learn-

ing administered.

Demographic and diabetic characteristics of the subjects, obtained from the patient profile sheets, were analyzed and described in terms of distributions, medians, and/or means. The test results were subjected to t-test analyses on several dimensions, and a number of demographic and diabetic traits were compared with their respective test scores by means of the Pearson Product Moment Correlation Coefficient.

The data supported the following

conclusions:

1. Diabetic patients taught by means of the "diabetic teaching tool" demonstrated a significantly higher level of learning about self-care than did patients taught in the unplanned manner.

2. Statistically significant differences were found between test scores of patients taught with the "diabetic teaching tool" and those receiving unplanned instruction, regardless of the duration of their diabetes. Thus *old* diabetics were able to derive as much benefit from the teaching tool as were *new* diabetics.

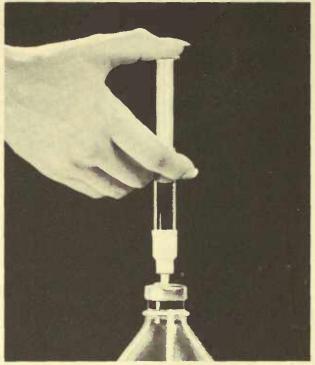
3. The level of learning demonstrated by patients taught with the "diabetic teaching tool" appeared to be independent of the following factors: age at time of teaching and testing, previous education, and age at onset of diabetes. Each of these factors was significantly related to the level of learning of patients receiving unplanned instruction.

4. Diabetic patients taught by means of the "diabetic teaching tool" cited the nurse as a valuable source of information regarding diabetic management more than five times as frequently as did patients receiving unplanned instruction.

Based upon these findings, several implications for nursing practice and recommendations for further research were suggested.

## Here is a new, fast and sterile

way to prepare Xylocaine infusions for life threatening arrhythmias



## **Xylocaine®**

(Lidocaine Hydrochloride Injection, Astra Std.)

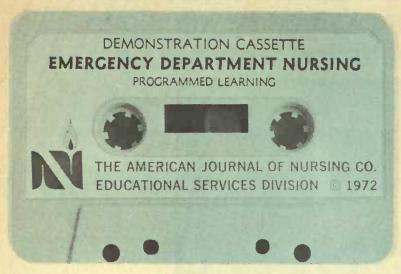
ne Gram

- The special 5 ml transfer syringe contains 200 mg/ml Xylocaine and can be added to infusion set-ups without removing solution from infusion flask or bag
- Cuts preparation time in half
- Easy and convenient to use
- Adds another link to the sterility chain
- Disposable
- Clearly labeled for positive safeguard against error

ASTRA Pharmaceutical Division, Mississauga, Ontario



## AV aids



Audio Tape Cassettes

#### TAPE CASSETTES

The American Journal of Nursing Company has released a series of eight instructional units, recorded on audio tape cassettes, on the subject "Emergency Department Nursing." This programmed learning series is behaviorally designed and intended for self-instruction by individuals or groups. Cost is \$150 per series.

Each unit includes a cassette with 30 to 45 minutes of taped programmed instruction and a workbook with illustrations. The total time required for each unit is 60 to 75 minutes. An instructor's manual and 10 student workbooks are provided with the series.

Subjects covered by the units are initial observation and assessment of the emergency patient; resuscitation and stabilization of patients; emergency management of shock, multiple injuries, and serious burns; and management of respiratory, cardiovascular, and neurological emergencies.

A sample tape can be borrowed from the library of the Canadian Nurses' Association, 50 The Driveway, Ottawa K2P 1E2. The library also has a descriptive brochure on this series.

#### LITERATURE AVAILABLE

Some practical guides to physical fitness are available free of charge from the department of health and welfare. One of these is a 16-page guide

for men and women, entitled Get Fit—Keep Fit. It explains the meaning and importance of physical fitness, tells how an individual can increase his or her physical activity in everyday life, explains what kind of exercise is best suited for adults, and describes the role of exercise in weight reduction and heart disease.

A 28-page physical fitness and training guide for young Canadians, also called *Get Fit — Keep Fit*, explains things such as training methods for various sports, diet, and immunization. Exercises are well illustrated.

Also available is an Athletic Injuries Wall Chart. However, it is only available in limited quantities for groups, schools, and other organizations. Write to Education and Information Services, Sport Canada, Health and Welfare Canada, General Purpose Building, Tunney's Pasture, Ottawa K1A 1B3.

☐ A brochure, *Drug Dependence Other Than Alcoholism*, second edition, has been published by the College of Physicians and Surgeons of the Province of Quebec, 1440 Ste. Catherine Street West, Suite 914, Montreal 107.

This 68-page practical guide to diagnosis and treatment includes a classification of psychotropic drugs; an explanation of attitudes physicians should adopt when dealing with a drug user and his family, with educators, with other members of the health team, and with

the police; and methods of treatment. Resources available throughout Quebec, such as youth clinics and specialized laboratories, are given. A two-page glossary of terms commonly used in the drug milieu is included at the end of the brochure.

☐ A Handbook of Canadian Film by Eleanor Beattie (280 pages, \$2.95 paperbound) has been published by Peter Martin Associates, 35 Britain St., Toronto. It contains information about making films in Canada, including data on film producers and writers, and reference chapters on distribution, technical services, archives, film collections, directories, and a bibliography.

☐ A bilingual film catalog is available from the World Health Organization, Avenue Appia, 1211 Geneva 27, Switzerland. The 52-page illustrated catalog lists films on a variety of topics: cardiovascular diseases, environmental health, eye diseases, family and public health, alcoholism and drug dependence, tuberculosis, and treponemal diseases. Distribution addresses for each film are given.

#### **FILMS**

☐ A number of 16mm films are available on loan from the library of the Canadian Hospital Association, 25 Imperial Street, Toronto, Ont. M5P 1C1. There is a \$15 service charge for all films, which includes the shipping and handling costs. The cost for rentals in the Toronto area is \$10. Films can be borrowed for one week only, but this does not include the shipping time.

does not include the shipping time.

The films include A Hospital Is...
(28 minutes, color); Emergency Treatment of Acute Psychotic Reactions
Due to Psychoactive Drugs (17 minutes, black and white); A Day in the
Death of Donny B. (15 minutes, black
and white), the story of a youngster
hooked on drugs in an urban ghetto;
An Affair of the Heart (18 minutes,
color), an explanation by heart specialists, in laymen's terms, of cardiac
disease in children; and The Straight
Child (13 minutes, color), a look at the
treatment a child receives for scoliosis.

50 THE CANADIAN NURSE

## **Double-Tex** Surgeons' Gloves

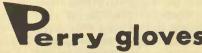


Need extra protection against slippage when you're handling slippery metal, glass and plastic surgical instruments? Try Perry's Double-Tex\* sterile, surgical gloves with light, velvet-textured palms.

You'll also get another exclusive Double-Tex feature. A special textured interior surface. Designed to protect against "in-the-glove slippage" caused by perspiration build-up during long procedures.

Double-Tex's strong, but thin, palm prevents binding. In addition, specially designed, curved fingers make Double-Tex a comfortable glove that is not fatiguing during long procedures.

Available in white and brown latex. Sizes 5½ through 9. Packaged in convenient peeldown, nonresealable outerwrap. Innerwrap provides a 276 square inch sterile field. Double-Tex. Just what you asked for and just from Perry.



A PRODUCT OF

90 Commercial Avenue, Ajax, Ontario

## books

The Hotplate Cookbook by Renata von Baeyer. 94 pages. Vancouver, Vancouver-Burrard Presbyterial United Church Women, 1973.

This paperback cookbook is small for easy storage in cramped quarters and has large print for easier reading. The physical format is matched to its purpose: a simple cookbook for people with limited housekeeping facilities, such as a hotplate and no refrigeration. All recipes are for one or two persons.

The recipes cover a wide range of soups, salads, desserts, and main dishes. The section 2M+ (two meals plus) covers how to shop for more than one day and use up the items purchased to produce a variety of dishes. The author's ingenuity is remarkable and the food sounds delicious.

In a covering letter that came with the book, Ms. von Baeyer says: "We are offering this cookbook as a public service to agencies and organizations that might be interested in distributing it to the people they serve." The book is not sold individually; 10 copies cost \$5.00. It may be ordered from: The Hotplate Cookbook, 4333 West Eleventh Avenue B, Vancouver 8, B.C.

Man's Anatomy, Physiology, Health and Environment, 4ed., by Nancy Roper. 520 pages. Edinburgh, Churchill Livingstone, 1973.

Reviewed by Jean Godard, former faculty member, School of Nursing, McGill University, Montreal, Quebec.

This paperback is a compendium of reasonably current information concerning the cell and genetics, growth and development, anatomy and physiology, epidemiology, nutrition, and health and illness.

With such a broad range of topics, this book is obviously an overview involving a systems approach to man and his environment. Stress is laid on the preventive aspects relating to environmental hygiene. Certainly, considerable space is devoted to plumbing, with illustrations of types of baths, showers, sinks, and taps.

The information given appears to be accurate and unbiased. The author does attempt to provide a thoughful and nonemotional approach to such

problems as addiction, overpopulation, and sexually-transmitted diseases. It is refreshing to read that "health is only meaningful when defined in personal functional terms." This is a definite advance from the older, more narrow, and definitive descriptions.

The writing is in rather a simplistic style and really skims the surface of some rather difficult material. The illustrations are well done, clearly drawn and labelled.

The content has a distinctly United Kingdom orientation, both in terminology, such as "0 levels" and plimsoles, and in the material described and the statistics used. At the end of each topic, the author inserts pertinent questions from the final papers for the General Register, set by the General Nursing Council for England and Wales. Again, the bibliography is largely from British nursing journals.

As the author is a former examiner for nursing, she is aware of the background of information that would be helpful for a general review by the

beginning nursing student.

In summary, this is a useful reference book for nursing assistants, other health workers, high school students, and beginning nursing students and, for the latter, as a preparation for examination. It provides a broad general overview of information. It is not written in sufficient depth for more advanced practitioners.

Supportive Care of the Surgical Patient by William M. Stahl. 270 pages. New York, Grune and Stratton, 1972. Canadian Agent: Longman, Don Mills, Ontario.

Reviewed by Lucille Moran, Assistant Professor, University of Ottawa, School of Nursing, Ottawa, Ontario.

The purpose of this book is to expose the normal physiological and biochemical processes that regulate homeostasis, the means used to assess the efficiency of homeostatic mechanisms, and the supportive measures required to optimize function of vital systems before, during, and after surgery

Each chapter begins with a description of normal physiological and biochemical mechanisms, using the concepts of homeostasis and stress to

illustrate how the human organism functions in health and adapts to stress. The role played by the systems involved in the exchange, transport, and regulation of chemical substances and functions necessary for the maintenance of equilibrium and adaptation are described in an interesting manner.

At this point, the focus shifts from the normal to abnormal responses occurring in conjunction with preexisting illness and surgery. Surgery is equated to a type of stress, arising from trauma and capable of causing disequilibrium in the patient. The importance of identifying any evidence of deficits or homeostatic imbalances, such as dehydration, diabetes mellitus, acidosis, renal failure, and so on, through various diagnostic tests that are mentioned, is described for the three phases of surgical care: preoperative, intraoperative and postoperative.

Similarly, specific medical measures, designed to correct any homeostatic alterations that may appear during these three phases of care, are stated as necessary means to achieve optimal function of "survival" systems in the surgical patient, citing, for example, parenteral alimentation, dialysis, and

drug therapy.

Although the exposition in the book is heavily oriented toward the physical sciences, the last chapter is devoted to the effects of the stress of surgery on the psyche of the patient. Possible behavioral reactions appearing either before or after surgery are mentioned, such as anxiety, fear of narcosis, denial, hostility, and regression. Emotional responses in children and the elderly, subjected to surgery, are stated. Finally, the terminal stage of life is dealt with by discussing why and how a surgical patient may react to impending death, and the role of the surgeon in this situation.

The book is based on medical science, dwelling heavily on physiology and biochemistry. Discussion of supportive measures is brief and concise to the extent that the author has achieved his purpose. The content is clear, relevant, and in harmony with the structure of some current nursing textbooks. This reference would be a valuable tool for teachers and a good library resource for students and nurses who care for surgical patients.

Maternity Nursing Today, by Joy Princeton Clausen, Margaret Hemp Flook, Boonie Ford, Marilyn M. Green and Elda S. Popiel. 959 pages. Toronto, McGraw-Hill Book Company, 1973. Reviewed by Peggy Saunders, Assistant Professor, School of Nursing, University of British Columbia, Vancouver, B.C.

If you have ever enjoyed the experience of finding just what you want, when you want it, then you have had an introduction to *Maternity Nursing Today*. Of particular timeliness is the inclusion of recent changes in concepts of the family, family roles, and family patterns. Even more timely is identification of the concomitant changes in nursing practice.

This book provides hope and a model for nurses who are making family-centered maternity nursing a reality. There is especially hope for the nurse who believes there is an important place in health care for one who accepts the responsibilities that contribute to the development of healthy, happy

parents and families.

Contributions have been made by sociologists, ecologists, a social worker, a nutritionist, nurses, and a geneticist. This wide background of authors' interests assures focus on pertinent issues of interdisciplinary care of families.

The book has been organized into five parts. The first part concerns the changing roles and self-concepts of people, and of the maternity nurse. A second concern is for the family today, including description of various family patterns presently observable in North America. The third section deals with the impact of individual differences on maternity care and in methods of teaching and counseling.

Part II involves planning the family; Parts III and IV discuss childbearing and childrearing; Part V focuses on complications of childbearing and child-

rearing.

An interesting aspect of organization is that the nursing process is interwoven throughout the book. Another point of interest is the way in which coping with stress and crisis is included in the section on complications of pregnancy. One final attribute is the emphasis placed on the use of the self by the nurse, and on the person, both the nurse and the patient.

An appendix of standards for maternity and child health practice provides guidelines for achieving the profession's obligations. The authors remind the reader that professional practitioners of nursing bear primary responsibility for the nursing care clients/patients receive; a timely reminder in view of the current rapid changes in delivery of health services.

The Control of Pain by Frederick Prescott. 146 pages. London, England, English Universities Press, 1972. Canadian Agent: Musson, Don Mills, Ontario.

Reviewed by Gail Laing, Lecturer in medical-surgical nursing, School of Nursing, University of Saskatchewan, Saskatoon, Saskatchewan.

This small paperback was written by a British doctor for the intelligent lay person and, from that point of view, is interesting and informative. It is one of a series of semiscientific books in the New Science series. Its general approach is historical with such chapters as: pain as seen through the ages, ancient anodynes, the story of anesthesia. This historical survey is commendable for its brevity and its wealth of interesting anecdotes.

From the nurse's point of view, the book is not always scientific. The author makes such questionable statements as, "women have a lower pain reaction threshold than men"; "the white races are considered to be on a higher evolutionary plane than the

colored races."

A drawback for the Canadian reader is that the author's experience is with the British system; he speaks, for example, of medicines in obstetrics and uses the British terminology for drugs, such as Pethidine for Demerol.

Discussion of how pain threshold and analgesic properties of a drug are measured is interesting. For instance, he speaks of a dolorimeter, an instrument used to measure pain in units called dols. Pain from a stomach ulcer rates as 2 to 3.5 dols; headache as .5 to 1.5 dols; surgery and childbirth as 10 dols. However, the experiments are not substantiated with footnotes, so you have to take his word for it.

The style is a bit repetitious. Many of the same things are said in the chapter on opiates and in the chapter on

drug addiction, for example. In fact, the chapters are fairly complete in themselves and could be read separately. The book has an index, but it is not complete.

In summary, it is an interesting little book but not especially valuable for Canadian nurses.

Arthritis and Back Pain by J. Crawford Adams. 200 pages. Baltimore, Md., University Park Press, 1972.

Reviewed by M. Leslea Anderson, Assistant Director of Nursing, Chedoke-McMaster Centre, Hamilton, Ontario.

The dearth of current literature concerning arthritis and its treatment may result in undeserved enthusiasm for this volume. While the author directs the book to those he terms "medical auxiliaries," among whom he numbers nurses, it is written in the simplest of language and relies heavily on definition to carry the message.

The types of arthritis, the drugs used in treatment, and the various personnel involved in giving treatment are dealt with briefly in the first 27 pages. Treatment, medical and surgical, is reviewed separately from the discussions of the disease entities, with the author, a surgeon, giving great emphasis to surgical treatment and only briefly explor-

ing medical therapy.

Discussion of those diseases classified as "arthritis" is well presented, and illustrated with appropriate diagrams, but requires more physiology in depth to be meaningful to even a new student nurse. One does find a clear outline of cause (where it is known), signs and symptoms, diagnostic tests, and treatment and its probable outcome. Details concerning treatment almost exclusively involve surgery. Even here, some of the newer techniques such as

SEPTEMBER 1973

#### books

the Gunsten Knee procedure are absent. Rehabilitation is mentioned in word only.

Since the author is English, difficulty may be encountered with some of his terminology and the names of a few drugs he lists. On the whole, however, his style is clear and manages not to "talk down" to the reader, yet remains

Nurses may find this book can be best used as a supplement when teaching patients, their families, and nonprofessional staff about arthritis. Nursing care is not considered in any way

by the author.

Poverty and the Child: A Canadian Study by Thomas J. Ryan. 254 pages. Toronto, McGraw-Hill Ryerson Limited, 1972.

Reviewed by F.L. (Nan) Sparks, Assistant Professor, School of Nursing, University of Calgary, Calgary, Alberta.

"This study represents an attempt to deal with one aspect of the complex question of poverty, that of the effects of early childhood experience in conditions of deprivation." Contributions have been made to the book from economies, medicine, physiology, psychology, and sociology. Although not easily read, as a reference text the book gives a concise picture of what it means and what it will mean to be poor in Canada.

Chapter 1 presents definitions of poverty and conveys to the reader some of the economic problems of families living on a marginal income. The chapter also states that "there exist no simple solutions to the problem of poverty but rather there may exist a set of alternative routes to its elimination." The book offers some of these

alternatives.

Chapters 2 to 5 describe certain characteristics of children coming from deprived conditions. The deleterious effects of poverty on physical growth, competence, and language and personality development are all well docu-

In Chapter 6, an analysis of school performance in relation to social class is made. It is found that the children from lower class families do less well in school and have lower educational and occupational aspirations than do those children from the higher class families. The most significant reason for this difference in performance between the lower and the higher class pupil is the difference in the teacherpupil relationship in each of these elasses. Unless this relationship is modified, the educational system will do little to change the position of the poor in Canada.

Chapters 7 and 8 cite the effects of early experience on later development and behavior in both animals and humans. Although the authors draw no firm conclusions, it would seem that poverty-deprivation yields an inferior product. Early environment and learning opportunities either expand or

limit potential.

The final portion of the book deals with the effects of early childhood intervention and makes some suggestions for future research and programming. Nonspecific recommendations are given for action by the federal, provincial, and municipal governments as well as advice to the school boards and the Vanier Institute of the Family. The "proposals attempt to go beyond the mere placing of income into the hands of low-income people as an attempt to eliminate those aspects of deprivation which do not necessarily go hand in hand with dollar deficit.

	MC	IV	NG?	
BEI	NG	MA	RRI	ED?

Be sure to notify us six weeks in advance, otherwise you will likely miss copies.

> Attach the Label From Your Last Issue OR Copy Address and Code

Numbers From It Here

#### NEW (NAME) /ADDRESS:

Street City

Zone

Prov./State

Please complete appropriate category:

I hold active membership in provincial nurses' assoc.

reg. no./perm. cert./ lic. no.

I am a Personal Subscriber.

MAIL TO:

The Canadian Nurse 50 The Driveway OTTAWA, Canada K2P 1E2

This book presents a convincing argument for research and change in the treatment of Canada's poor. An excellent reference list is at the end of each chapter and a final bibliography and listing of resource centers can add much to the reader's understanding of the disadvantaged child.

Again, although difficult to read, the book would be a good addition to the library of the teacher or elinician in family or community health nursing.

Form and Function of Written Agreements in the Clinical Education of Health Professionals by Margaret L. Moore, Mabel M. Parker, and E. Shepley Nourse. 81 pages. Thorofare, N.J., Charles B. Slack, 1972. Reviewed by June R. Scollie, Assistant Professor, School of Nursing, University of Manitoba, Winnipeg,

Although this study was carried out in relation to elinical experience for physieal therapy students, the authors' elaim that contracts between educational and elinical facilities should be carefully developed is valid for all participants in health services.

Chapters 1 and 2 provide the background from which the book was developed, a need to have "mutually beneficial affiliations for clinical education between educational and clinical institutions and agencies." The remaining chapters clarify and provide guidelines for interinstitutional agreements relat-

ing to clinical experience.

Items that may require inclusion in contracts or agreements are listed at the end of Chapter 2. Such a profile can be useful for those institutions developing mutual contracts, as the trend toward service agency participation in planning professional education continues to grow. Joint and individual responsibilities are included for consideration.

The authors state the contracts must be mutually agreeable and developed by negotiators from both concerned institutions. Suggestions or guidelines for this development are given in the final chapter. Again, areas of joint and individual responsibilities are described. Not all of these may be suitable to every situation but the reader will be reminded to consider, even negatively, the particular item of responsibility. For example, health insurance (p.58), is probably not a necessary concern in Canada. But the authors also mention other insurance or liability coverage that may be a need.

Factors that may require consider-

ation in developing an agreement with clinical education institution are drawn together in a concise listing in the final chapter and may be more easily understood than more formal texts on contracting. Many areas of possible concern are indicated and the proposed guidelines can be visualized in terms of the need of the nursing school and the clinical agency.

Concept Formalization in Nursing: Process and Product by Nursing Development Conference Group. 226 pages. Boston, Mass., Little, Brown, 1973. Canadian Agent: Lippincott, Toronto.

Reviewed by Margaret D. Bennett, Assistant Professor, McMaster University School of Nursing, Hamilton,

Ontario.

This books illustrates the developmental process and implementation of a particular nursing model. Its publication is timely because nursing is striving to develop a theoretical framework for both nursing education and nurs-

ing practice.

The 11 authors of this book formed the Nursing Development Conference Group (NDCG) and since 1968 have been struggling to formalize a concept of nursing that would create a theoretieal framework for nursing. The book is a unique effort to communicate the process of concept development and organization over time.

The purpose and the basic underlying presuppositions of structuring nursing knowledge lead the authors to present their basic philosophy of science to justify their conceptual approach. A historical overview of nursing models and philosophy by prominent nursing theorists is presented and analyzed by the authors, using their general standards of adequacy. The choice of nursing models for the overview was purposely limited to those published in books and is possibly a limit to the scope of their investigation.

The theorists critiqued even such notables as Florence Nightingale, Clara Weeks-Shaw, Bertha Harmer, Hester Fredrick and Ethel Northam, Virginia Henderson, Dorothea Orem, lda Jean Orlando, Martha Rogers, Ernestine Wiedenback, and Myra Estrin Levine. There is some question as to whether the theorists would agree with the NDCG analysis. Markedly absent is Dorothy Johnson and her regulatory-

equilibrium model of nursing.

The NDCG describe the process of selecting Orem's general philosophy of nursing. The concepts from Orem's nursing model are defined and described within a general systems context, giving the references and symbols, and showing the system's interrelation-

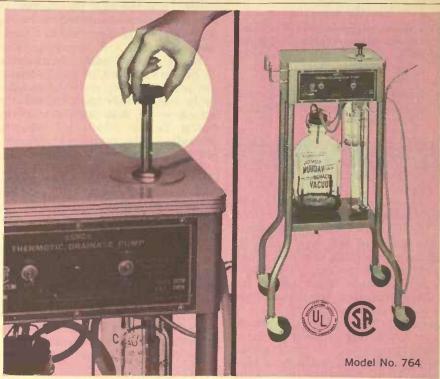
ships. Their eoncepts are freely developed and described in terms of their eharaeteristic functions and linkages that define the nursing system. The writer believes that many of the propositions supporting their concept definitions could be questioned by human behavior experts. The theoretical base for the understanding of human behavior as it relates to the nursing concepts is not identified.

In the fourth chapter, the authors present statements concerning the formal object of nursing, the focus of the process of nursing, and a new

premise about nursing as a discipline. One can take issue with some of the statements, although it is the excitement of their intellectual process that shows a way for nursing theorists and researchers.

In the last chapter, the NDCG demonstrate how their nursing model has been made operational in an undergraduate nursing curriculum and in nursing practice.

In summary, the book gives concrete evidence of the excitement and challenge for those who are concerned about the structuring of nursing



## Finger-tip solution to a frequent problem: Thermotic® Pump Flushing Device

- Patented flushing device speeds and simplifies clearing drainage tubes. One stroke of the handle eliminates need of disconnecting nasal tube and use of syringe to accomplish the same purpose.
- Safer . . . 35 to 50 ml. of solution enters the tubing on flushing stroke rinsing tube clean. The approximately 5 ml. that enters the patient's alimentary canal is removed when suction automatically resumes.
- Stores in 30% less space . . . four units store in only 3'-7" x 1'-41/2" of space.
- Aerovent® Positive overflow protection that prevents damage to pump by automatically admitting air to suction line when contents of suction bottle reach a predetermined weight.
- Sturdy tubular steel constructed stand that stays where you want it, moves easily on 3" conductive rubber casters.

Gomco Thermotic Drainage Pumps have maintained their number ONE position in the field for over 30 vears.



See your Surgical Supply dealer or write:

#### SURGICAL

MANUFACTURING CORPORATION 828 East Ferry Street Buffalo, New York 14211

SEPTEMBER 1973

#### books

knowledge and practice with a theoretical base. The title of the book belies the excitement of its contents: it is a valuable contribution to the nursing literature. Nurse educators will find it thought-provoking, and even if they do not agree with the content, study of the NDCG process will give insight into the development of nursing theory.

Patient Care in Endocrine Problems (Saunders Monographs in Clinical Nursing) by Roberta T. Spencer. 230 pages. Toronto, Saunders, 1973. Reviewed by Hattie Lee Shea, Assistant Professor, Faculty of Nursing, University of Western Ontario, London, Ontario.

This book is designed as a nursing reference to present comprehensive cover-

age of endocrine dysfunctions.

The process of nursing is the aim of this presentation. This aim is adequately achieved in the sections covering the adrenals and the pancreas. Patient teaching and involvement in care are presented in depth with supporting pathophysiologic data. These two sections would be of value to beginning students studying the complexities of hormonal imbalances.

Much of the remainder is factual content pertaining to diseased states. Nursing process is not the emphasis here. For those persons with a keen interest in biochemistry, there is an II-page appendix covering the chemical structure of the hormones.

In spite of the emphasis on disease, I feel this is a good reference. The author's expressed interest in mass screening, early diagnosis, patient teaching, and patient involvement in care are all of great importance in the process of nursing. All these factors are emphasized frequently and should make an impact on nursing students and nursing practitioners.

Challenge to Community Psychiatry by Archie R. Foley. 203 pages. New York, Behavioral Publications, 1972. Reviewed by Alice E. Caplin, Assistant Professor, School of Nursing, University of Saskatchewan, Saskatoon, Sask.

Although this book is subtitled A Dialogue between Two Faculties, the reader will find that she is laboring under a misconception if she thinks this book

will tell her much about two different views on community psychiatry. The student of group process will be similar-

ly confused.

The book is an account of a four-day institute held in 1968 for the faculty of psychiatry at Boston University, conducted by faculty from Columbia University, financed by the National Institute of Mental Health, and accompanied by a descriptive research project.

Two primary concerns are reported as basic to the planning of the institute, one being the absence of "courses and programs of inservice training and continuing education in community psychiatry" and the other the polarization between groups committed to the traditional psychotherapy and to community psychiatry.

Dr. Bernard Bandler, the chairman of Boston's division of psychiatry, according to his own report sandwiched in the middle of the book, had a hidden agenda — the democratization of the Boston faculty, which was becoming increasingly restive under his "benevo-

lent, paternalistic leadership."

Dr. Bandler notes, "In these days when every group hoists the banner of power above its name — student power, community power, black power — the faculties have been strangely silent; no bugles have sounded for faculty power. There is good reason for this reticence because of the authoritative departmental structure of our medical schools . . . . It takes courage to speak out and to disagree." It appears that in Dr. Bandler's mind the primary purpose of the institute was to begin democratization to reduce the possibility of a show of faculty power in his department.

A fourth reason for the institute was the dissatisfaction of residents over the emphasis on analytical psychiatry as opposed to community psychiatry. This institute, though in the planning stage for several years, was actually held only one month after violence erupted on the campus of Columbia.

A Challenge to Community Psychiatry, interlarded with frequent reassurances between planners and conductors that "I'm alright, You're alright" and condescending statements frequent about the brightness and intelligence of the participants, is an embarrassingly naive book. We are asked to applaud while a timid and uneasy profession bravely dips a naked big toe into the waters of group discussion, generously inviting psychologists, social workers, a sprinkling of others, and eight registered nurses to join it. Of the eight nurses, none of them members of the nursing faculty, five participated. Only one filled in the postinstitute questionnaire. You can skip the whole thing without feeling guilty.

The Critical Issues of Community Mental Health by Harry Gottesfeld. 296 pages. New York, Behavioral Publications, 1972.

Reviewed by Mona McLeod, Professor, School of Nursing, University of Manitoba, Winnipeg, Manitoba.

This is a valuable book for anyone involved in teaching, community health services, or research. The issues raised and discussed are not only pertinent for those concerned about mental health, but are applicable to any professional group undergoing change, such as nursing. The compilation is refreshing and thoughful as it presents the traditional and the new points of view about services to people, and the preparation of individuals to give service. The contributors include members of the health professions and the social sciences. The presentations have been carefully prepared, with well-developed viewpoints, supported by bibliography.

In one section titled "Traditional Psychotherapy," one writer speaks of "the tack of recognition among professions as to how long it takes to acquire clinical maturity, the undervaluing of clinical skills, moving into other related fields such as research, administration and teaching without having had the painful but rewarding experience of working with persons over a sufficiently long period of time to experience repeatedly within himself the turmoil of personal growth and change, as these are induced by repeated experiences of interacting and adjusting to patients

as they change."

This statement can be contrasted with a statement from another contributor who indicates "that impersonal methods (contrary to the hypothesis that transference effects are important) work as well as personal methods." These viewpoints, which appear to be poles apart, have in common a concern for the relief of human suffering; however, the second statement reflects the dissatisfaction expressed by a number of contributors with the insensitivity of controlling establishments, and the apparent lack of success in the reduction of mental illness and emotional unhappiness in society.

Emphasis is given to sociological, economic, and political factors, which some writers see as contributing to the creation, development, and maintenance of mental illness in society. There was some fascinating evidence to support these views, and nurses might well look at this aspect in order to learn the role they may be unwittingly playing.

The issue of role diffusion presents some thoughful considerations of the prepared person versus the indigenous worker or the person with short-term

SEPTEMBER 1973

preparation. The proliferation of new workers, the expanding team, appears to contribute to greater fragmentation of services and increasing dissatisfaction of those who are the recipients of service. One must keep in mind that we are all receivers at some time in our lives.

This book is about mental health issues; however, I feel it has much to say to all the health professions. The concepts put forward for consideration are vital as we construct curriculums, plan for community health services, and identify needed research.

Psychiatric Nursing in the Hospital and the Community by Ann C. Burgess and Aaron Lazare. 427 pages. Englewood Cliffs, N.J., Prentice-Hall, 1973.

Reviewed by Marjorie Carroll, School of Nursing, University of Ottawa, Ottawa, Ontario.

The theoretical foundation for this text is the humanistic theory of man. The authors focus on the human dimension in psychiatric nursing and, although the book is directed to the student in the psychiatric setting, the principles are clearly applicable to all areas of nursing and to situations outside the profession.

The text is divided into four parts. The first, "Basic Concepts", is of importance in interacting with and caring for a patient in any setting. Interviewing and nursing assessment are given consideration, along with the concept of the "stall" in the therapeutic process. The authors have borrowed the term from aerodynamics and present their analogy in an interesting manner. A chapter on the management of the medically ill and dying has been included in which emphasis is placed on integrating psychiatric nursing skills into one's "professional style of nursing."

In "Nursing Management of the Clinical Syndromes" both diagnostic categories and concepts of behavioral patterns are considered. The authors support the position that "there is a need for some logical ordering of patient difficulties" to facilitate "clinical judgment regarding treatment plans and goals." They advocate a framework for nurses to discuss patient care with mental health professionals who use the diagnostic terminology.

"The Community" looks at the patient in his own community. Considered to a limited degree are many issues of "individual-family-community interaction in the framework of psychic distress," such as crisis intervention, grief process, alcohol and drug abuse,

and contemporary problems such as the battered child, youth, family disorganization, and the elderly in the commu-

Finally, a review of historical and theoretical perspectives of psychiatric nursing and a glossary of current terminology have been included.

This book is suitable as a basic text or reference. The content is presented in an orderly manner with bibliographic references and descriptive examples. Although of value to a basic student, this text will be useful to teachers and practitioners of psychosocial aspects of nursing, psychiatric nursing, and community mental health nursing.

Behavioral Threat & Community Response by William C. Rhodes. 147 pages. New York, Behavioral Publications, 1972

Reviewed by Barbara Herrick Lee, Assistant Professor, Community Mental Health Nursing, School of Nursing, University of British Columbia, Vancouver, B.C.

It is unfortunate for all of us that the most prominent characteristic of this book is its unreadability. The author has done a competent job of conceptualizing the dynamics of community response to threatening sectors; however, getting through his sentence structures and unorthodox use of words uses much of the reader's energy.

If one is willing to undertake the rather exhaustive trek through the pages of this book, the reward is a quite highly developed and detailed analysis of the politics and operational patterns of community behavior-regulator systems.

The overall focus of the book, as described by the author, is "the interlocutor processes and apparatuses of the community that have evolved to reconcile the claims of the individual with the claims of society." Underlying this focus is the psychoanalytic interpretation of social unrest and upheaval — the price of civilization is neurosis, as socialization consists primarily of training in self-denial, self-rejection, and self-alienation.

Given this unhappy state of affairs, a community responds by making scapegoats of its deviants. The existing behavior-regulator systems not only fail to relieve community suffering, but also perpetuate the vicious threat-recoil cycle. The author undertakes an exploration in depth of the relationships between the threatening minority groups (alcoholics, mentally ill, retardates, legal offenders); the culture bearing, threat-reactive public; and the protectorate sector, composed of politicians and professionals.

LEAD A FASHION LIFE #1232 about \$25.00



#### books

The book offers familiar concepts regarding reconstruction of the form and direction of the behavior-regulator apparatus and the process of behavior management. Of great interest was the author's recommendation of the loosening of agency ties to single professional guilds and his calling for multiple guild

Given nursing's growing involvement in the community and desire to become more responsive to community needs, the study of community dynamics in relation to behavior management seems profitable and necessary. This text would serve as a useful, although at times rather tedious, reading for post-baccalaureate students and practitioners of nursing.

Basic Medical Statistics by Anita K. Bahn. 260 pages. New York, Grune & Stratton, 1972. Canadian Agent: Longmans, Don Mills.

Reviewed by Margaret C. Cahoon, Professor and Chairman of Research, Faculty of Nursing, University of Toronto, Toronto, Ontario.

This is a textbook to take the threat out of statistics for physicians and nurses. It is directed toward the development of a holistic view of the few basic concepts that underlie statistical reasoning.

It is a semiprogrammed type of selflearning and testing textbook intended for the beginning student or the continued self-education of those who want to learn statistics. It is intended for those who want to acquire statistical comprehension sufficient to read research reports and to conduct simple statistical tests on quantitative or qualitative data.

In each chapter there is a presentation of new material followed by exercises, both true-and-false type and numerical problems with step-by-step solutions and discussions. A summary, glossaries of new terms and of symbols, and cumulative reviews are included at appropriate points.

The illustrative problems are from medicine, but they are understandable and of interest to other health professionals, whether students or graduates.

This book is an outcome of years of experience in teaching statistics to students in medicine, nursing, and so-cial work, and to scientists. The first twelve chapters were serialized in The Woman Physician (now the Journal of the American Medical Women's Association) beginning in the September 1969 issue. Students of the Medical College of Pennsylvania "tested" the original draft of this book.

Perhaps the next edition of this book could be titled Basic Health Science Statistics to bring it to more of those who need this approach. Nevertheless, it is bound to make its way from medical students to their colleagues.

Statistical Principles in Health Care Information by S. James Kilpatrick, Jr. 228 pages, Baltimore, Md., University Park Press, 1973.

Reviewed by Nancy Garrett, Research Officer, Canadian Nurses' Association, Ottawa.

The author has given us a much-needed book that meets the objectives out-

lined in the preface.

The reader can be assured that the author's claim, that no mathematical background is required, is actually true. The cookbook approach is avoided and practical reasons given for all procedures described. A wealth of examples familiar to health workers is used to illustrate points and principles presented. Although explicit description of each step is given and repetition used to excellent advantage, the reader's intelligence is respected and interest maintained at a high level.

Common pitfalls of the unsuspecting are pointed out, for example, by noting not only the importance of knowing the sample size on which percentages are based but also why numbers are important. The practice of using several decimal places to mislead the reader with an impression of great accuracy is

also pointed out.

Other examples of manipulation of statistics show the importance of visualizing the basic data and the variables influencing the area of interest.

The first two chapters illustrate the collection, presentation, interpretation, and use of health care information and data. These chapters provide the basis for the following 10 chapters, which discuss the more common statistical measures: location and dispersion, association and correlation, probability, as well as survey design, and decisionmaking theory. Well-chosen examples are used throughout the book, making easy what is so often presented in a way that makes beginning statistics a complicated subject. To illustrate the decision-making tree, an example used is the debt of patients in the hospital and the process involved including probabilities of partial repayment, total repayment, or the option of writing off the debt if a former option fails. This type of example is much more meaningful than that of using probabilities of winning games.

Some examples are taken from American context; nevertheless, the concepts are important and well demonstrated. They in no way reduce the efficacy of this text as a teaching tool.

The author uses the same care to reinforce learning techniques of calculation as he has used to reinforce learning principles. He refers back to the familiar in introducing a new approach, such as that on cost-function on page 182. The equation is given and then, before the reader becomes dismayed at still another equation, he is reminded that, "This expression is the same as that used to calculate a mean from a frequency distribution (see exercise 5.1)." The equation showing the calculation of a mean from a frequency distribution then follows to show the exact similarity. No steps are missed in teaching calculations.

An added benefit of this book is the recognition that computers have come to stay and have their part in the lives of all of us. The "role of the computer," is a welcome section. The more common functions of computers are described in admirably simple language that stimulates desire in the reader to learn

more about the subject.

Examples of the use of computers in hospitals are given, and a personality given to the machine by saying, "Typically the machine sits humming to itself, and after many long, repeated, and often complex calculations may print out a simple number as the answer.' In describing simulation techniques, an important aspect of clinic care is acknowledged by noting that "Models of outpatient emergency clinics can be developed which will predict the range of waiting times of patients.

Although the author never preaches, he has managed to extract almost all the major pitfalls and myths involved in interpretation of statistics and com-

puter use.

Important to the Canadian reader is the mention made of services in which Canadian hospitals participate, such as the PAS (Professional Activity Study) data processing system. Another bonus is an appendix of mathematical expressions and notations, which is often left

to the student to compile.

Some may complain about the lack of tables, found in the appendix of most statistics books. However, tables have been included, where appropriate to teaching particular calculations. If the reader of this text is stimulated to continue his studies in statistics, he will find tables for significance testing and the like in other books. In the meantime, it seems likely that he will have learned how to use them more efficiently through the method presented in this text than he would have done otherwise.

Although the book has been designed for health care professionals who need a grasp of statistical principles, it would be useful to any beginner interested in learning not only statistical procedures but also the reasons for them.

#### accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, except reference items, may be borrowed by CNA members, schools of nursing and other institutions. Reference (R) items (archive books and directories, almanacs and similar basic books) do not go out on loan. Theses (also R) are on Reserve and may go out on Interlibrary loan only.

Request for loans should be made on the "Request Form for Accession List" and should be addressed to: The Library, Canadian Nurses' Association, 50 The Driveway, Ottawa, Ont. K2P 1E2

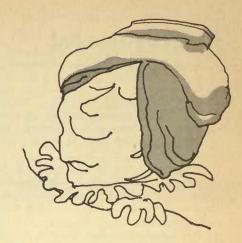
No more than *three* titles should be requested at any one time.

#### BOOKS AND DOCUMENTS

- 1. Abstracts of papers submitted at Colloquium on Nursing Research, Montreal, March 28, 29, and 30, 1973. Montreal, 1973. 55p.
- 2. Aids and deterrents to the performance of associate degree graduates in nursing, by Thais Levberg Ashkenas. New York, National League for Nursing, 1973. 160p. (League exchange no. 99)
- 3. Album, annuaire 1973, de Maisons d'enfants et d'adolescents de France. Grenoble, France, Editions Gaston Gorde, 1973. 295p.
- 4. Aspects psychiatriques des soins infirmiers, par Rosette Poletti. Paris, Centurion, 1973. 179p. (Infirmières d'aujourd'hui, no.4)
- 5. Associate degree education for nursingcurrent issues, 1972. Papers presented at the fifth conference of the Council of Associate Degree Program, Dallas, Texas, March 1-3, 1972. New York, National League for Nursing, Dept. of Associate Degree Programs, 1972. 82p.
- 6. Back to nursing, by Ruth Perin Stryker. 2ed. Toronto, Saunders, 1971. 371p.
- 7. Canadian government programmes and services; government organization. Don Mills, Ont., CCH Canadian Limited, 1973. 474p.
- 8. Cardiovascular disorders; patient care, by Pat M. Ashworth and Harry Rose. London, Baillière Tindall, 1973. 309p.

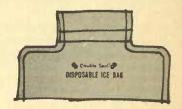
SEPTEMBER 1973

- 9. Community health nursing, by Kathleen M. Leahy et al. 2ed. New York, McGraw-Hill, 1972. 358p.
- 10. Community health nursing; evolution and process, by Catherine W. Tinkham and Eleanor F. Voorhies. New York, Appleton-Century-Crofts, 1972. 320p.
- 11. Concepts basic to nursing, by Pamela Holoclaw Mitchell. New York, McGraw-Hill, 1973. 470p.
- 12. Continuing nursing education, by Signe Skotte Cooper and May Shiga Hornback. Montreal, McGraw-Hill, 1973. 261p.
- 13. Descriptive medical electronics and instrumentation, by Terence C. Karselis. Thorofare, N.J., Slack, 1973, 373p.
- 14. The development of studies in health manpower; report of a WHO Scientific Group. Geneva, World Health Organization, 1971. 56p. (Its Technical report series no. 481)
- 15. Effects of health education on smoking habits in school students: a longitudinal study. Pt. 1, Smoking behavior and attitudes of grade 7 Ottawa students, Jan. 1969, by E. M. Thomas and F.R. Wake, Ottawa, 1972. 211p.
- 16. An experiment in nursing curriculums at a university, by June T. Bailey et al. Belmont, Calif., Wadsworth, 1971. 558p.
- 17. An experiment in nursing: planning, implementing, and assessing planned change, by Jannetta MacPhail. Cleveland, Ohio, Case Western Reserve University, 1972, 97p.
- 18. Family health care, by Debra P. Hymovich. New York, McGraw-Hill, 1973. 462p. 19. Family planning education; parenthood and social disease control, by Charles William Hubbard. St. Louis, Mosby, 1973. 173p. 20. Florence Nightingale, sa vie et son oeuvre, par Yvonne Krebs-Japy. Paris, Poinat, 1932. 134p. R
- 21. L'Hôtel-Dieu de Montréal (1642-1973). Montreal, Hurtubise HMH, 1973. 254p. (Les cahiers du Québec. Collection histoire)**R**
- 22. L'infirmière et l'organisation du travail hospitalier, par Andre Montésinos. Paris, Centurion, 1973. 198p. (L'infirmière d'aujourd'hui, no. 5)
- 23. Instructor's manual for Koontz and O'Donnell: Principles of management, by Robert C. Yost and Paul O'Rourke. 5ed. Toronto, McGraw-Hill, 1972. 190p.
- 24. International medical care: a comparison and evaluation of medical care services throughout the world. Edited by John Fry and W.A.J. Farndale. Wallingford, Pa., Washington Square East, 1972. 341p.
- 25. An international study of health expenditure and its relevance for health planning, by Brian Abel-Smith. Geneva, World Health Organization, 1967. 127p. (World Health Organization. Public health papers no. 32)
- 26. Introduction to ergonomics by W.T. Singleton. Geneva, World Health Organization, 1972. 145p.
- 27. Introduction to operating-room technique, by Edna Cornelia Berry and Mary Louise Kohn. 4ed. New York, McGraw-Hill, 1972. 342p.
- 28. Jeanne Mance, 1606-1673, par Marie-



# Keep a cool head

Our ice bag will keep a cool anything. It's unique too. It reduces cross infection because it's disposable. The sealing method eliminates the need for caps or stoppers. It's also durable, economical and easy to store. It's really the only ice bag of its type. We'll send you one free so you can see for yourself. We'll also send you a catalogue.



FOR FREE DOUBLE SEAL DISPOSABLE ICEBAG MAIL THIS COUPON TODAY.



Scholl (Canada) Inc.
HOSPITAL PRODUCTS DIVISION
174 Bartley Drive
Toronto 16, Ontario

NAME	
TITLE	
HOSPITAL	
ADDRESS	
CITY	PROV.

THE CANADIAN NURSE 59

#### accession list

Claire Daveluy. Suivie d'un Essai généalogique sur les Mance et les De Mance, par M. Jacques Laurent. 2éd. Montréal, Fides, 1962. 418p. R

29. Learning to be; the world of education today and tomorrow, by International Commission on the Development of Education. Paris, Harrap (for Unesco), 1972. 313p. Chairman: Edgar Faure.

30. Length of stay in PAS hospitals, Canada 1971. Ann Arbor, Michigan, Commission on Professional and Hospital Activities, 1972. 163p.

31. Library practice in hospitals; a basic guide. Edited by Harold Bloomquist et al. Cleveland, Case Western Reserve Univ. Press, 1972. 344p.

32. Man, work and organizations; an introduction to industrial and organizational psychology, by Bernard M. Bass and Gerald V. Barrett. Boston, Allyn and Bacon, 1972. 673p.

33. Marie Morin, premier historien canadien de Villemarie, par Esther Lefebvre. Montréal, Fides, 1959. 211p.R

34. Marraine Mance, par Pia Roseau. Montréal, Beauchemin, 1962. 106p.R

35. Mary Adelaide Nutting, pioneer of modern nursing, by Helen E. Marshall. Baltimore, Johns Hopkins Univ. Press, 1972. 396p.

36. Medical records, medical education and patient care; the problem-oriented record as a basic tool, by Lawrence L. Weed. Cleveland, Case Western Reserve Univ. Press, 1970. 273p.

37. Nurse utilization: a patient care systems project. Final report. A project of the Wisconsin Regional Medical Program, Inc., and under the auspices of University of Wisconsin-Milwaukee School of Nursing. Milwaukee, Wisc., 1972. 117p.

38. Population planning. Sector working paper. Washington, D.C., World Bank, 1972. 83p.

39. Preventive medicine, community health, and social services, by Meredith J.B. Davies. 2ed. London, Baillière Tindall, 1971, 331p.

40. Primary health care—everybody's business. Papers presented at the sixth annual meeting, Oct. 12-13, 1972, Miami Beach, Fla. New York, National League for Nursing, Council of Hospital and Releated Institutional Nursing Services, 1972. 56p.

41. Principles of management: an analysis of managerial functions, by Harold Koontz and Cyril O'Donnell. 5ed. Toronto, McGraw-Hill, 1972. 748p.

42. Proceedings of International Conference on Education in the Health Sciences, First, The Hague, Oct. 8-12, 1972. The Hague, International Society for Education in the Health Sciences, 1973. 84p.

43. Psychological nursing care of the aged.

Comp. by Irene Mortenson Burnside. New York, McGraw-Hill, 1973. 214p.

44. Reference group theory and delinquency, by Robert E. Clark. New York, Behavioral Publications, 1972. 129p.

45. Report 1970-71. Washington, D.C., Association of University Programs in Hospital Administration, 1972. 48 p.

46. Resocialization: an American experiment, by Daniel B. Kennedy and August Kerber. New York, Behavioral Publications, 1973. 191p.

47. A resource guide in sex education for the mentally retarded by Project on "Recreation and Fitness for the Mentally Retarded" in cooperation with School Health Division of the American Association for Health, Physical Education and Recreation and the Sex Information and Education Council of the United States. New York, National Association for Retarded Children, 1969.

48. Road accidents: medical aid. A guide for medical practitioners involved at the scene of motor traffic accidents, by Hanns Pacy. Edinburgh, Livingstone, 1971. 136p.

49. Safe use of pesticides; twentieth report of the Expert Committee on Insecticides. Geneva, World Health Organization, 1973. 54p. (Its Technical report series no. 513)

50. Soins intensifs coronariens; guide à l'usage des étudiants, des réanimateurs et des infirmières spécialisées, par Lawrence E. Meltzer et al. Paris, Maloine, Excerpta Medica, 1973.

51. Statistical principles in health care information, by S. James Kilpatrick. Baltimore, University Park Press, 1972. 228p.

52. Study guide and cases to accompany Koontz & O'Donnell: Principles of management, by John F. Halff. 5ed. Toronto, McGraw-Hill, 1972. 248p.

53. Supportive care of the surgical patient, by William M. Stahl. New York, Grune & Stratton, 1973. 270p.

54. Target 2067; Canada's second century, by Leonard Bertin. Toronto, Macmillan, 1968. 297p.

55. Ten year health plan for the Americas. Report of Special meeting of Ministers of Health of the Americas, Third, Santiago, Chile, October 1972. Santiago, Chile, 1972.

#### PAMPHLETS

56. Aspects of respiratory care nursing, by Nursing Advisory Service of NLN-NTRDA. New York, National League for Nursing, 1973. 12p.

57. Brief on employer-employee relations in the province of British Columbia. Vancouver, Registered Nurses' Association of British Columbia, 1972. 12p.

58. Cooperative responsibility for health care. Paper presented at 63rd annual meeting of CPHA in Saskatoon, June 8, 1972, by Claude A. Lanctot. Sherbrooke, P.Q., 1972.

59. Designing a system of care; the clinical perspective. Presented at the National Conference on Alternatives to Institutional Care for Older Americans . . . at Duke Uni-

versity, Durham, North Carolina, June 1-3, 1972, by Eric Pfeiffer. Durham, N.C., 1972, 10p.

60. Evaluation of community health centres. Geneva, World Health Organization, 1972, 42p. (Its Public Health papers no. 48)

61. Exercise equivalents. Denver, Colorado, Colorado Heart Association, Cardiac Reconditioning and Work Evaluation Unit. n.d. 24p.

62. Exercise testing and training of apparently healthy individuals: a hand book for physicians. New York, American Heart Association, Committee on Exercise, 1972. 40p.

63. Guidelines on the optimum utilization of nursing personnel, as approved by Registered Nurses' Association of British Columbia and British Columbia Hospital's Association. Vancouver, Registered Nurses' Association of British Columbia, 1972. 10p. 64. Hospital care in the 70's...forces for change. Papers presented at the 2nd annual meeting of the National League for Nursing-American Hospital Association held at New York, N.Y., on June 20-22, 1972. New York, National League for Nursing, 1973. 37p.

65. The law of negligence, by Terry J. Weuster. Saskatoon, 1972. 10p.

66. Maternal and child health services planning. Geneva, WHO Medlars Centre, 1972. 13p.

67. Nursing in Sri Lanka, by T.B. Sheehan. Colombo, Ceylon, 1973. 9p.

68. Parents and teenagers, by Margaret Hill. New York, Public Affairs Committee, 1973. 24p. (Its Public Affairs pamphlet no. 490)

69. Physician's handbook for evaluation of cardiovascular and physical fitness. Nashville, Tenn., Tennesse Heart Association, Physical Exercise Committee, 1971. 43p.

70. Reducing the odds, by Maurice W. Cuming. Rev. London, King Edward's Hospital Fund for London, 1972. 22p.

71. Sex ratio in the progeny of women who used the pill as a contraceptive. Geneva, WHO Medlars Centre, 1972. 15p.

72. Special problems of nursing manpower by H. Rose Imai. Geneva, World Health Organization, 1972. 23p.

73. The status of women in CUPE. Ottawa. Canadian Union of Public Employees, 1971. 35p.

74. Structure, aims & objectives, services & pharmacy associations. Toronto, The Canadian Pharmaceutical Association, 1973. 9p.

75. Teacher autonomy and teacher decision making. Ottawa, Canadian Teacher's Federation, 1973. 10p. (Bibliographies in education, no. 34)

76. Tenure. Ottawa, Canadian Teacher's Federation, 1973. 20p. (Bibliographies ir education no. 33)

77. Voluntary male sterilization, by Donalc I. Dodds. Toronto, Damian Press, 1970

78. What can we do about limited vision, by Irving R. Dickman. New York, Public Affairs Committee, 1973. 28p. (Public affair pamphlet no. 491)

GOVERNMENT DOCUMENTS Canada

79. Dept. of Labour. Accident Prevention and Compensation Branch. If you have an accident; what to do and how to do it. Ottawa. Information Canada, 1972, 18p.

80. —. Union Management Services Branch. Coming to terms with conflict. Ottawa, Information Canada, 1973. 15p.

81. Dept. of Manpower and Immigration. Career outlook community college, university 1972/73. Information Canada, 1973. 1 vol.

82. - Supply & demand new university graduates, 1972. Ottawa, Information Canada, 1972, 49p.

83. Dept. of National Health and Welfare. Public Health research grant. General instructions. Ottawa, 1971, 19p.

84. Dept. of National Health and Welfare. Report to...on Canadian research on psycho-social aspects of cigarette smoking 1960-1972, by J. Bergin and F.R. Wake. Ottawa, 1973. 67p.

85. - Socio-psychological aspects of cigarette smoking 1964-1972. Ottawa, 1966-1973. 4 vols.

86. — Health Protection Branch. A compilation of the drug quality assessment program. Ottawa, Information Canada, 1972. 82p. (Rx Bulletin, vol. 3, supp. 1)

87. Economic Council of Canada. The economy to 1980: staff papers. Ottawa Information Canada, 1972. 334p.

88. Health and Welfare Canada. Canada

pension plan; report 1970-71. Ottawa, Information Canada, 1972, 58p.

89.—. A report prepared by the Toronto Smoking Withdrawal Study Centre. Ottawa, 1970? 1 vol.

90. Labour Canada, Economics and Research Branch. Working conditions in Canadian industry, 1971. Ottawa, Information Canada,

91. Laws, statutes, etc. Canada Corporations Act. R.S.C., c. C-32 amended by 1970 (1st supp.), c. 10 and regulations made under the Canada Corporations Act. Ottawa, Information Canada, 1972. 271 p.

92. Metric Commission. Steering Committee no. 9, Consumers Services and Labour Organizations. Background material. Introductory meeting, Ottawa, March 15, 1973. Ottawa. 1 vol.

93. National Science Library. Health Sciences Resource Centre. Conference proceedings in the health sciences held by the National Science Library. 2ed. Ottawa, 1971.

94. Royal Canadian Air Force. 5BX plan for physical fitness. 3ed. Ottawa, Information Canada, 1962. 32p. (RCAF Pamphlet

95. —. 10BX plan for physical fitness. rev. Ottawa, Information Canada, 1962. 46p. (RCAF Pamphlet 30/2)

96. Statistics Canada. Health statistics. Ottawa, Information Canada, 1973. 17p.

97. - Trusteed pension plans financial

statistics 1971. Ottawa, Information Canada,

Ontario

98. Ministry of Health. Research and Analysis Division. Nursing education in Ontario universities; an historical sketch. Toronto, 1970. 14p.

99. —. —. Professional training bursaries for registered nurses in Ontario 1944-1972. Toronto, 1973, 16p.

100. -. The supply and demand for registered nurses and registered nursing assistants in Ontario. Toronto, 1972. 63p.

101. Ministry of Labour. Research Branch. Collective agreement expirations. Toronto, 1973. 294p.

102. -. -. Wages, hours of work and overtime pay provisions in selected industries, Ontario, 1972. Toronto, 1973. 24p.

STUDIES DEPOSITED IN CNA REPOSITORY COLLECTION

103. Description of New Hampshire's first orientation-training program for family planning personnel, by Nancy Garrett. Ann Arbor, Mich., 1971. 18p.R

104. A discussion paper on specialization in nursing. A summary report prepared for the Canadian Nurses' Association, by Alice J. Baumgart, Ottawa, Canadian Nurses' Association, 1973. 24p.R

105. Professionalism in nursing, by Patricia Ellen B. Valentine. Calgary, Alta., 1973. 94p. (Thesis (M.A.) - Calgary) R

#### **Request Form** for "Accession List"

#### CANADIAN NURSES' ASSOCIATION LIBRARY

Send this coupon or facsimile to: LIBRARIAN, Canadian Nurses' Association, 50 The Oriveway, Ottawa K2P 1E2, Ontario.

Author

Ple	ase	lend	me the	fol	lowir	ng public	ation	ıs, li	isted in t	he	
							issue	e of	The Can	adian	Nurse,
or		my				waiting					

Short title (for identification)

Request for loans will be filled in order of receipt. Reference and restricted material must be used in the CNA

Borrower ..... Registration No. Position .....

...... Date of request .....

#### JOHNS HOPKINS HOSPITAL

#### **RN** director of adult medical nursing service

for 250-bed facility. Position requires Master's degree and demonstrated ability.

#### CONTACT:

Miss DORIS ARMSTRONG, R.N. **DIRECTOR OF NURSING** JOHNS HOPKINS HOSPITAL **BALTIMORE, MARYLAND 21205** TELEPHONE: (301) 955-5160

Item

#### classified advertisements

#### ALBERTA

DIRECTOR OF NURSING required for 21-bed active treatment hospital. Previous supervisory experience a definite asset. Apply stating qualifications, experience, references and salary expected to: Administrator, Berwyn Municipal Hospital, Berwyn, Alberta.

TWO REGISTERED NURSES required September 1 or October 1 for general duty in 22-bed hospital. Salary according to A. H. A. recommendation. Apply to: Matron-Administrator, Consort Municipal Hospital, Consort, Alberta.

REGISTERED NURSES required for 50-bed general hospital, situated on main line between Edmonton and Calgary. Salary and personnel policies as negotiated by AARN. Apply to: Mrs. E. Harvie, R.N., Lacombe General Hospital, Lacombe, Alberta.

REGISTERED NURSES. The Red Deer General Hospital requires nurses with an interest in a variety of Medical, Surgical, Obstetrical and Paediatric positions. We have several immediate openings in our progressive 240-bed hospital. Please apply to: Personnel Department, Red Deer General Hospital, Red Deer, Alberta or phone 346-3321 for further information.

#### BRITISH COLUMBIA

INTENSIVE CARE UNIT TRAINED NURSES required rolo-bed General Hospital. Salary as per RNABC contract. Nurses' Residence accommodation available. Apply to: Director of Nursing, Powell River, General Hospital, 5871 Arbutus Street, Powell River, British Columbia.

#### ADVERTISING RATES

FOR ALL

#### CLASSIFIED ADVERTISING

\$15.00 for 6 lines or less \$2.50 for each additional line

Rates for display advertisements on request

Closing date for copy and concellation is 6 weeks prior to 1st day of publication month.

The Canadian Nurses' Association does not review the personnel policies of the hospitals and agencies advertising in the Journal. For outhentic information, prospective applicants should apply to the Registered Nurses' Association of the Province in which they are interested in working.

Address correspondence to:

### Canadian Nurse



50 THE DRIVEWAY OTTAWA, ONTARIO K2P 1E2

#### BRITISH COLUMBIA

REGISTERED NURSES required for 100-bed accredited hospital located in the Cariboo region of B.C.'s Central Interior. Vacancies in operating room (out patients), maternity, extended care and general duty positions in acute care. Salary and personnel policies in accordance with RNABC Agraement. Rooms available in Nurses' Rasidence. Apply to: Director of Nursing, G.R. Baker Memorial Hospital, 543 Front Street, Quesnel, British Columbia.

OPERATING ROOM NURSE wanted for active modern acute hospital. Four Certified Surgeons on attending staff. Expariance of training desirable Must be engine for B.C. Hegistration. Nurses residence available. Salary \$687 per month starting. Apply to: Director of Nursing, Mills Memorial Hospital, 2711 Tetrault St., Terraca, British Columbia.

GENERAL DUTY AND OPERATING ROOM NURSES for modern 450-bed hospital with School of Nursing. RNABC policies in effect. Credit for past experience and postgraduate training. B.C. Registration required. For particulars write to: Acting Director of Nursing Service, Victoria General Hospital, Victoria, British Columbia.

EXPERIENCED NURSES required in 409-bed acute Hospital with School of Nursing. Vacancies in medical, surgical, obstetric, operating room, pediatric and Intensive Care areas. Basic salary \$672.
\$842. B.C. Registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

EXPERIENCED GENERAL DUTY NURSES — required for small up-coast hospital. Salaries start at \$672.00. Residence accommodation at \$25.00 per month. 20 days annual vacation. Transportation paid from Vancouver, B.C. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia.

GENERAL DUTY NURSES for modern 41-bed hospital, located on the Alaska Highway. Salary and personnel policies in accordance with RNABC. Accommodation available in residence. Apply: Director of Nursing, Fort Nelson General Hospital, Fort Nelson, British Columbia.

GENERAL DUTY NURSE wanted for 87-bed modern hospital. Nurses Residence. Salary \$646.00 per month for BC Registered. Apply: Director of Nursing, Mills Memorial Hospital, Terrace, British Columbia.

#### MANITOBA

NURSING DIRECTOR: Applications are invited for the position of Director of Nursing of the 17-bed Reston Community Hospital. Salary commensurate with training and experience. Applications in writing giving full resume of work experience and all other related information to be directed to: Chairman, L.L. Ludlam, Reston Community Hospital, Reston, Manitoba.

SWAN RIVER VALLEY HOSPITAL IN SWAN RIVER, MANITOBA requires immediately an EVENING SUPERVISOR. This is an 88-bed accredited hospital. Preferred if the applicant has taken the Nursing Unit Administration course and has had some supervisory experience. For further information contact Mrs. A. Nemetchek, Personnel Department, Swan River Valley Hospital, Swan River, Manitoba.

#### NOVA SCOTIA

REGISTERED NURSES, PSYCHIATRIC NURSES AND CERTIFIED NURSING ASSISTANTS. General staff positions available in this modern, 270-bed psychiatric hospital, located in the Annapolis Valley. Orientation and Inservice provided. Excellent personnel policies. Salary according to scale. For lurther information direct inquiries to: The Director of Nursing, Kings County Hospital, Waterville, Nova Scotia.

OPERATING ROOM SUPERVISOR required for 140bed hospital. Must have post graduate training. An opportunity to enjoy beautiful Cape Breton. Apply to: Administrator, 'St. Joseph's Hospital, Glace Bay, Nova Scotia.

#### ONTARIO

SUICIDE SYMPOSIUM, October 11th and 12th, 1973, Woodstock, Ontario. Speakers from all over Canada Further information and registration forms from: SUICIDE SYMPOSIUM, Oxford Mental Health Centra, Box 310, Woodstock, Ontario.

NURSE 2 NURSING EDUCATION required for mental retardation hospital. Registration as a nurse in Ontario with a post graduate certificate in nursing from a university of recognized standing, or a general B.A. Irom a university of recognized standing with concentration in a behavioural science. 1973 salary is \$10,031. to \$11,274. annually. Excellent personnel policies. For particulars apply: Assistant administrator, Ontario Hospital, P.O. Box 130, Aurora, Ontario.

REGISTERED NURSES required by 70-bed General Hospital situated in Northern Ontario, Salary scale—\$610.00—\$720.00 allowance for experience. Shift differential, annual increment, 40 hour week. Excellent personnel policies. For particulars apply-Director of Nursing, Lady Minto Hospital at Cochrane. Cochrane, Ontario.

REGISTERED NURSES for 34-bed General Hospital Salary \$646. per month to \$756. plus experience allowance. Excellent personnel policies. Apply to Director of Nursing Englehart & District Hospitalno., Englehart, Ontario.

REGISTERED NURSES required for a new 79-bed General Hospital in bilingual community of Northern Ontario. French language an asset, but not compulsory. Salary is \$645. to \$758. monthly with allowance for past experience, 4 weeks vacation after 1 year and 18 sick leave days per year. Unused sick leave days paid at 100% every year. Master rotation in effect. Rooming accommodations available in town. Excellent personnel policies. Apply to: Personnel Director, Notre-Dame Hospital, P.O. Box 850. Hearst, Ont.

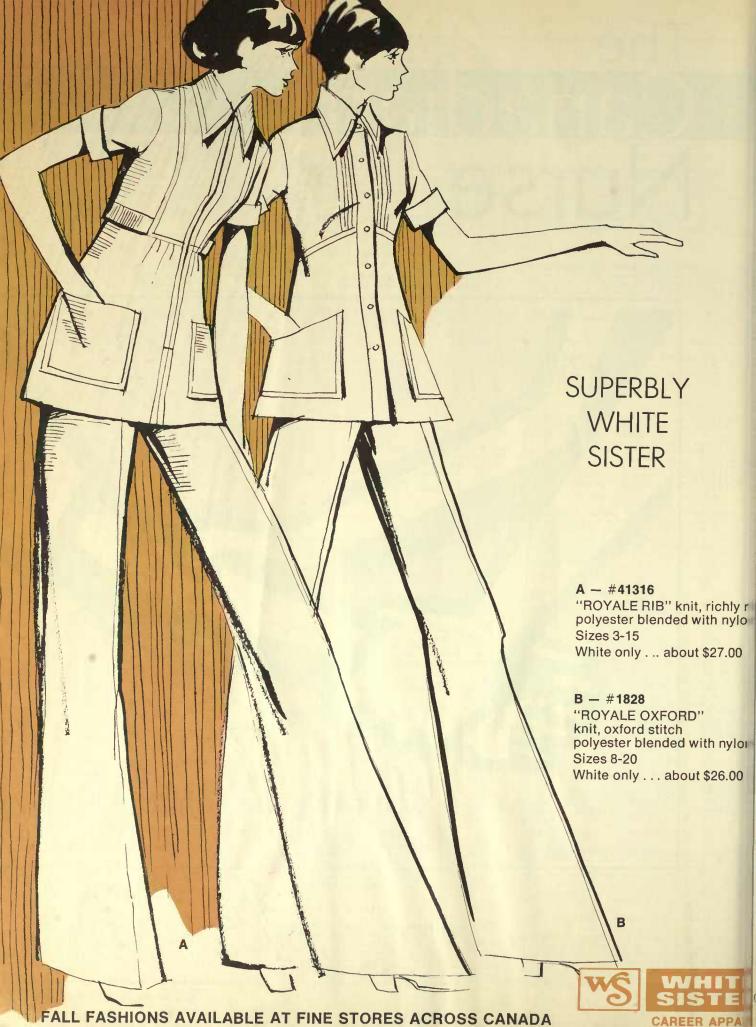
REGISTERED NURSES required by a modern wellequipped hospital. Situated in a progressive Community in Northern Ontario. Excellent employee benefits and working conditions. Apply to: Director of Nursing, Sensenbrenner Hospital, Kapuskasing. Ontario.

REGISTERED NURSES AND REGISTERED NURSING ASSISTANTS for 45-bed Hospital Salary ranges include generous experience allowances. R.N. s salary \$630. to \$730. and R.N.A.'s salary \$430. to \$505. Nurses' residence — private rooms with bath — \$40 per month. Apply to: The Director of Nursing. Geraldton District Hospital, Geraldton, Ontario.

REGISTERED NURSES for General Duty and I.C.U — C.C.U. Unit required for 162-bed accredited hospital, Starting salary \$645.00 with regular annual increments. Excellent personnel policies. Temporary residence accommodation available. Apply to The Director of Nursing, Kirkland and District Hospital Kirkland Lake, Ontario.

# The Canacian Nurse







NURSING

PRACTICE

Little, Brown

pective parents.

BEHAVIOR

Springer

Hein

variety

Beth Israel Hospital, Boston

PARENT EDUCATION

Clark

**COMMUNICATION IN NURSING** 

. A comprehensive presentation of current interdisciplinary practices in respiratory and nursing

April 1973

Presents a simple, formal model of the com-

munication process between nurse and patient, but

emphasizes the need to use variety in meeting

July 1973

LEADERSHIP TECHNIQUE IN EXPECTANT

duct well planned educational sessions for pros-

PRESSURE: A Programmed Sequence

**EFFECTIVE APPROACHES TO PATIENT** 

MONITORING CENTRAL VENOUS

venous pressure of concern in nursing.

. Designed to equip the nurse instructor to con-

June 1973

. A programmed text on the aspects of central

June 1973

How the nurse should approach an emotionally

disturbed patient when giving direct nursing care.

Springer

June 1973

\$5.50

\$4.25

Recent releases or clinical npetence

> THE BODY'S RESPONSE TO TRAUMA: Fractures

Clissold

In this programmed text, fracture is used to demonstrate the responses of the cells of the body June 1973 \$6.75

WINTERS' PROTECTIVE BODY **MECHANICS: A Manual for Nurses** 

Bilger and Greene ... Concentrates on the physical and physiological principles underlying the body movements that need to be initiated to achieve therapeutic objectives in patient care.

Springer May 1973 ADMINISTERING NURSING SERVICE

8 DiVincenti . . . A straight forward presentation of everyday approaches to the management of nursing services and the application of management theories to the care of patients. Little, Brown December 1972

MATERNAL-CHILD NURSING Broadribb and Corliss A family centered text for students being prepared to give direct care to mothers and children. about \$11.00 September 1973

PERSPECTIVES IN HUMAN 10 DEVELOPMENT: Nursing Throughout the Life Cycle

Sutterley and Donnelly

Emphasizes a multi-disciplinary, holistic view of man, the promotion and maintenance of health as well as intervention in times of physical, emotional and social stress. Lippincott May 1973

THE PRACTICE OF MENTAL HEALTH 11 **NURSING: A Community Approach** Morgan and Moreno

Reflects the dynamic quality of psychiatric care in a community setting and desirable colleague relationships required for successful treatment of the emotionally disturbed.

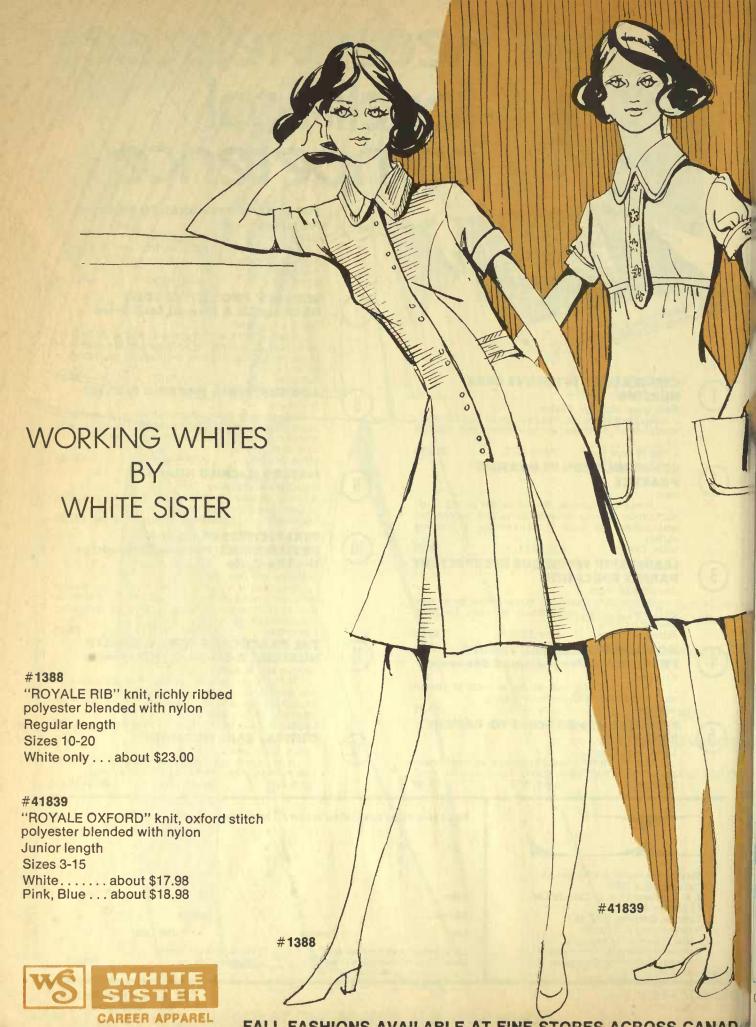
Lippincott May 1973 flexible cover \$5.95

**CRITICAL CARE NURSING** Hudak, Gallo and Lohr

A comprehensive course in the area of critical care nursing unexcelled in depth and content. about \$9.95 Lippincott August 1973

Serving the health professions in Canada since 1897 J. B. Lippincott Co. of Canada Ltd. 75 Horner Ave. Toronto, Ontario M8Z 4X7 Representing in Canada: Little, Brown and Company Blackwell Scientific Publications Ltd. Springer Publishing Company, Inc.

Please send me the book(s) whose number(	s) I have circled	
1	5	9
2	6	10
3	7	11
4	8	12
Name		
Address	Position	
City Province	Postal C	ode
Payment enclosed (send postpaid)	Use my Chargex number	
Books may be returned within 15 days	Charge and bill me	CN10-73



## The Canadian Nurse



A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 69, Number 10

October 1973

The views expressed in the editorial and various articles are those of the authors and do not necessarily represent the policies or views of the Canadian Nurses' Association.

4	Letters	48	In a Capsule
7	News	50	Research Abstracts
16	New Products	52	Books
24	Names	55	AV Aids
16	Dates	56	Accession List

Executive Director: Helen K. Mussaiiem • Editor: Virginia A. Lindabury • Assistant Editors: Liv-Ellen Lockeberg, Dorothy S. Starr • Editorial Assistant: Carol A. Dworkin • Production Assistant: Elizabeth A. Stanton • Circulation Manager: Beryl Darling • Advertising Manager: Georgina Clarke • Subscription Rates: Canada: one year, \$6.00; two years, \$11.00. Foreign: one year, \$6.50; two years, \$12.00. Single copies: \$1.00 each. Make cheques or money orders payable to the Canadian Nurses' Association. • Change of Address: Six weeks' notice; the old address as well as the new are necessary, together with registration number in a provincial nurses' association, where applicable. Not responsible for journals lost in mail due to errors in address.

Manuscript Information: "The Canadian Nurse" welcomes unsolicited articles. All manuscripts should be typed, double-spaced, on one side of unruled paper leaving wide margins. Manuscripts are accepted for review for exclusive publication. The editor reserves the right to make the usual editorial changes. Photographs (glossy prints) and graphs and diagrams (drawn in india ink on white paper) are welcomed with such articles. The editor is not committed to publish all articles sent, nor to indicate definite dates of publication.

Postage paid in cash at third class rate MONTREAL, P.Q. Permit No. 10,001. 50 The Driveway, Ottawa, Ontario. K2P 1E2

© Canadian Nurses' Association 1973.

In a letter to the editor, Pat Barr, an RN from Alberta, points out the unfairness of the Canada Pension Plan to female contributors (p.5). "Why," Ms. Barr asks, "should the spouse and family of the contributor of one sex receive less benefit from the plan than the spouse and family of the contributor of the other sex?" Why, indeed?

In 1970, the Royal Commission on the Status of Women in Canada raised the same point, and recommended that the Canada Pension Plan (and the Quebec Pension Plan) be amended to eliminate this discrimination.

So far, the federal government has done nothing to change this section that discriminates against the working woman and her family. And there is evidence that it has no intention of changing it in the near future, even though the Plan is being reviewed by the federal and provincial governments. (See Editorial, "Canada Pension Plan Discriminates," p.29).

Ms. Barr urges nurses to try to get this inequity corrected. "Write to your member of parliament and to the minister of Health and Welfare Canada," she writes. "Ask your professional organization [provincial and national] to make a submission to the minister. Write to your ocal newspaper. Make a fuss."

Amen. — V.A.L

## letters

Letters to the editor are welcome.

Only signed letters, which include the writer's complete address, will be considered for publication.

Name will be withheld at the writer's request.

Authors respond to letter

In reply to Elisabeth Vincent's letter to the editor (August 1973, page 4), we intended the article on conjoined twins as a guide for nurses confronted with a rare and complex nursing problem. We believed it was better to err on the side of emphasis on detail.

We believe the emotional security of babies and the prevention of infection in the nursery are sufficiently important to warrant reemphasis for the health care team of today and tomorrow. -Wendy S. Dirksen and Dorothy T. Meilicke, Edmonton, Alberta.

Sharing patients' interests

l wish to comment on the article "What will happen to Mr. Lang?" (May 1973) by Leslie Horton. Teachers are not the only ones who use patients. We all need to be aware that using people selfishly

As a geriatric nurse with 15 years' experience, I find no need to say the staff is too busy to keep up a patient's

interest.

In Mr. Lang's case, each person on his ward should be intelligent about baseball for his sake. It takes no extra time, but it does take genuine concern to say, "Dinner is ready, Mr. Lang. Do you think Cincinatti will win today?" and listen for his answer. It also shows concern to say "Wow! what a run for the Expos," or ask, "Do you want your bath early today so you will be ready to watch the game?"

Instead of complaining about working a minute overtime, nurses should stop by the television set at 4:00 P.M. and ask the score before they leave. If there are only five persons on a ward and each one makes a different comment about the game each day, the Mr. Langs will remain much more in con-

tact with the world.

Sure we are busy, but many times we are too lazy to think of each patient's interests. — Ruth E. Lemke, R.N., Camrose, Alberta.

**Responds to August letter** 

In response to the letter from an RN, Ontario (August 1973, page 5), I would like to point out that the mere change in nursing education from the hospital setting to community colleges is not a criterion on which to determine a poorer quality of patient-centered care.

It is the nature of our profession to be involved in change. Many developments have brought us to the place where we find nursing education at present; not all these developments were acclaimed as positive advancements when they were introduced.

Although each of us might not fully agree with a new program, we have some responsibility to support our colleagues in the courses they are beginning. Many nurse educators are also expressing doubts, concerns, and, on occasion, some negativism; however, they continue to participate in this effort to broaden the learning process.

The quality of the teaching personnel and the philosophies of nursing and education are the components that mould the concept of patient care the nurse of the future will hold. These things, and not the physical presence or absence of specific, structured hospital procedures, are what inspire motivation, judgment, and a sense of purpose in the student nurse.

We need care plans for all we do in giving quality care to our patients. In this manner, the responsibility for care and treatment are shared and increased, as it becomes the duty of each team member to evaluate the suggested care plan, add to, update, and suggest alternatives.

Yes, everything we do is a "service," but should not remain merely a physical doing. It must be coupled with sufficient background knowledge of principles and a flexibility to adapt to change.

If support, rather than a predetermined, judgmental attitude, is given to any change, evaluation of that change will be more objective. If the patient-centered care we are to give is to be supportive and adaptable to individual circumstances, these threads should be evident in learning that care. — Penelope I. Jessop, Reg.N., B.Sc.N., nurse clinician, Hamilton, Ontario.

#### MOVING? **BEING MARRIED?**

Be sure to notify us six weeks in advance, otherwise you will likely miss copies

Attach the Label From Your Last Issue Copy Address and Code Numbers From It Here

NEW (NAME) /ADDRESS:

Street City Zone

Please complete appropriate category:

I hold active membership in provincial nurses' assoc.

reg. no./perma cert./ lic. no.

I am a Personal Subscriber.

MAIL TO:

Prov./State

The Canadian Nurse 50 The Driveway OTTAWA, Canada K2P 1E2 Nurses must respect all beliefs

I would like to suggest to the puzzled operating room nurse (Letters, August 1973, page 5) that if she cannot carry out the duties she was hired to perform, which involve assisting with a therapeutic abortion, her only course of action is to resign.

If a nurse wishes to subscribe to a particular religious belief in her personal life, that is her privilege. But it must not interfere with her professional duties. Surely nurses must respect the rights and beliefs of all creeds and not maintain that their own view about an issue is "right" and all other views are

"wrong."

Christianity, with its many divisions, is only one faith among many others in this world. Let no one claim to have the whole truth about anything. Let all nurses accept and care for patients as they are and not presume to judge their actions as right or wrong. — Margery L. Poole, B.Sc.N., Toronto, Ontario.

Regarding the puzzled nurse of the Roman Catholic faith (Letters, August 1973, page 5), who is perplexed over abortions: I, too, am puzzled.

Does being a nurse of the Roman Catholic faith give anyone the right to be more morally indignant about abortions than a nurse of the Mormon, Jewish, or Protestant faith? Name one church that openly endorses abortions under any condition.

I am for abortions, but I do not question anyone's right to protest. Legalized therapeutic abortions are a fact; they will not go away. Perhaps the puzzled OR nurse should transfer to another department where she will not have to compromise her religious and moral convictions. - RN, Alberta (name withheld on request).

Pension plan discriminates

I would like to draw the attention of registered nurses to the sexual discrimination in the Canada Pension Plan. I can best illustrate what I mean by

giving my own example.

My husband and I have both contributed to the Canada Pension Plan since 1966. We have three elementary school-age children. If my husband were killed in a car accident tomorrow, his estate would receive a death benefit from the plan. In addition, I would receive a monthly pension of not more than \$71.12, plus \$28.15 a month for each child — a maximum of \$155.57. This would not be enough to live on, but it would be a big help with the expenses of living.

However, if I were killed in a car accident, my estate would receive a lump sum, \$560 maximum, and that would be it as far as the Canada Pension Plan is concerned. This is an unjust, illogical, and perhaps illegal situation, illegal because Canada has legislation against discrimination on the grounds

of race, religion, and sex.

Why should the spouse and family of the contributor of one sex receive less benefit from the plan than the spouse and family of the contributor of the other sex? I am sure there are many married nurses with children who would like to know that the money they would ultimately be entitled to if they live could be used for their family if they

I hope other nurses will join me in trying to get this inequity corrected. Write to your member of parliament and to the minister of health and welfare. Ask your professional organization to make a submission to the minister. Write to your local newspaper. Make a fuss. — Pat Barr, Edmonton, Alberta.

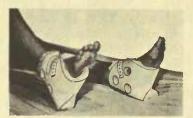
#### **Letters Welcome**

Letters to the editor are welcome. Because of space limitation, writers are asked to restrict their letters to a maximum of 350 words.

#### **NEW POSEY DEVELOPMENTS**

The new Posey products shown here are but a few included in the complete Posey Line. Since the introduction of the original Posey Safety Belt in 1937, the Posey Company has specialized in hospital and nursing products which provide maximum patient protection and ease of care. To insure the original quality product, always specify the Posey brand name when ordering.

The Posey Pelvic Seat effectively prevents sliding forward and falling from chair. This device is secured from behind on any type of chair and is comfortable for the patient. #4432 (cotton), \$7.50.



The Posey "Swiss Cheese" Heel Protector has new hook and eye fasteners for easy application and sure fit. Available in convoluted porous foam or synthetic fur lining. #6121 (fur lining), #6122 (foam), \$4.80 pr.



The Posey Body Stop Kit with soft padded bar provides a quick, simple, and effective method of preventing a patient from "scooting" forward in any standard wheelchair. #8155, \$24.95.





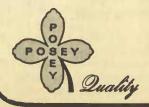
The Posey Houdini Security Suit is for the patient that will not stay in bed or wheelchair. Vest and lower portion interlock with waist belt making it virtually escape-proof. #3412, \$15.00 complete.



The Posey Foot-Guard with new "T" bar stabilizer simultaneously keeps weight of bedding off foot, helps prevent foot drop and foot rotation. #6412, \$21.00.

Send for the free all new POSEY catalog - supersedes all previous editions.

Please insist on Posey Quality - specify the Posey 8rand name.



**POSEY PRODUCTS** Stocked in Canada ENNS & GILMORE LIMITED 1033 Rangeview Road Port Credit, Ontario, Canada

# Here is a new, fast and sterile way to prepare Xylocaine infusions

for life threatening arrhythmias



# **Xylocaine®**

(Lidocaine Hydrochloride Injection, Astra Std.)

ne Gra

- The special 5 ml transfer syringe contains 200 mg/ml Xylocaine and can be added to infusion set-ups without removing solution from infusion flask or bag
- Cuts preparation time in half
- Easy and convenient to use
- · Adds another link to the sterility chain
- Disposable
- · Clearly labeled for positive safeguard against error

ASTRA Pharmaceutical Division. Mississauga, Ontario



ASTRA

#### news

Nfld. Hospital Nurses Reject **New Collective Agreement** 

St. John's, Nfld. — Registered nurses working in hospitals and health agencies throughout Newfoundland have voted against a one-year collective agreement negotiated on their behalf by a bargaining committee of the Assotion of Registered Nurses of Newfound-

ARNN mailed the ballots last August - a peak vacation period - to the approximately 1,600 nurses in the bargaining unit; some 1,200 of these nurses voted. Between July 25 and August 14, ARNN had conducted a series of meetings at major centers to explain the bargaining position to membership.

David Sparkes, ARNN's employment relations officer, told The Canadian Nurse there were two main reasons for the rejection. One was that the 12 percent-salary increase: offered (retroactive to April 1, 1973) was considered inadequate. The other reason was that the nurses want recognition for some of their past nursing experience. Nurses in the province do not receive any credit for this experience.

The starting salary for a Nurse 1 in the new agreement was \$6,749, compared with \$6,000 in the previous twoyear agreement. The largest increase in salary was for a nursing education coordinator, beginning at \$8,368, compared with \$6,720 in the last agreement.

In addition to the salary increase, the new agreement offered a block payment of \$240 to each nurse who was on staff April 1, 1973, and who continued on staff until the agreement was signed. This amount was negotiated to compensate nurses for a four percent increase that all hospital employees, except nurses, received April 1, 1972. The other hospital workers also have accepted or have been offered an eight percent increase effective April 1, 1973.

Other improvements for the nurses in the agreement they rejected included: better hours of work and overtime pay; a \$100 increase in the annual allowance paid to nurses in small hospitals, nursing stations, and regional nursing practices to compensate for overtime, standby, and callback; improved provisions for statutory holidays, including time off and pay for work on these holidays; improved sick leave benefits; additional

provisions for compassionate and special leave; and more detailed provisions for staff development and termi-

nation of employment.

There were 12 new articles in the one-year contract, covering employee rights, check off, escort duty, position protection, suspension and discharge, special allowances, temporary assignment, injury on duty, transfers and portability, conditions of employment, a classification committee, and a labor management committee.

The reason stated in the agreement for establishing a classification committee was to give adequate consideration to the need for a career structure at the Nurse I level. Such a committee would consist of representatives of the ARNN, the Newtoundland Hospital Association, and necessary government depart-

According to the agreement, the labor management committee would be composed of four ARNN appointees and four NHA appointees, and would meet at least three times a year "to develop mutual understanding of the relationship between employee and employer and to investigate matters of concern that are not the subject of grievance.

ARNN's negotiating committee met early in September to determine what strategy to follow next. Mr. Sparkes said he thought the general mood of the nurses was to go back to negotiations, rather than take strike action.

Last August 13, legislation that made strikes illegal in Newfoundland was repealed. Since then, nonmedical workers have gone on strike in three hospitals in the province.

**CNA Executive Director Advises** School Of Nursing In Uruguay

Ottawa — Helen K. Mussallem, executive director of the Canadian Nurses' Association, spent five weeks this summer in Montevideo, Uruguay, on a short-term assignment for the Pan American Health Organ.zation/World Health Organization. Dr. Mussallem left Ottawa July 22.

In an interview with The Canadian Nurse soon after her return in September, Dr. Mussallem said she was selected for the assignment because of her previous involvement with nursing in Latin America (News, January 1973,

page 14) and because of the work and studies she has done in Canada on nursing and health services.

The main purpose of this assignment was to advise the faculty of the university school of nursing on whether the newly-revised educational program would prepare the graduates to meet the health needs of the country and whether the objectives stated for the program would be met through the curriculum.

Dr. Mussallem was also asked to advise the faculty members on a nurse career study they are beginning, and to assist and participate in a one-week seminar on the evaluation of nursing education programs. The seminar was for full- and part-time faculty (nurses and nonnurses), nurses in the clinical field and in the ministry of health, other health workers, and students.

Before the seminar was held, she had discussions with the director of the school, the faculty, and two student representatives. Dr. Mussallem referred to "the courage of the young director and her concern for finding newer and better ways of educating the students.' She said the people at the school of nursing were "young, eager, and concerned with the health services.

An orientation program planned by the faculty gave her an introduction to the current political situation in the country and its effect on educational programs. Although she found that "tensions were evident" throughout her stay, every effort was made to minimize

the tension and stress.

"The discussions on the evaluation of the curriculum were free and frank, Dr. Mussallem said. She explained that the four-year program is divided into four levels: the first gives students opportunities to work with and understand families and groups in the community; the second deals with the promotion of health for families; and in the final two, the students progress toward working with children, adolescents, and older persons in sickness and health.

"These students come into nursing concerned with the welfare of the people first. Therefore, this curriculum is attractive to them," remarked Dr. Mussallem. She called the curriculum "a very positive approach to nursing," which prepares the students to work as team members in the communities.

#### news

There are only two schools of nursing in the country, both in Montevideo. The university school was started in 1950. The other, a hospital school, is much older. Dr. Mussallem noted that the university school has been taking in 30 students a year, although 100 were accepted in the last class to increase the number of nurses in the country. These students must have completed 12 years of education to be admitted to the school.

In 1972, there were about 950 nurses employed in the country. The ratio of nurses to doctors is 1:3. Uruguay, the smallest country in South America, has a population of approximately three

million.

Before she returned to Canada, Dr. Mussallem attended the first annual general meeting of the Commonwealth Caribbean Regional Nursing Body. The meeting was held in Bridgetown, Barbados, from August 27 to 31. Fifteen countries are members of this nursing

body.

Among the main subjects discussed at the meeting were the revision of the criteria to be used for evaluating schools of nursing in the Commonwealth Caribbean and an accreditation program for schools of nursing in the region. The meeting strongly supported a proposal for a bachelor of science degree in nursing at the University of the West Indies

This body is being financed by several groups, including PAHO. The nongovernmental organization division of the Canadian International Development Agency has also provided assist-

ance.

ICN Plans Celebration For 75th Anniversary In 1974

Geneva, Switzerland — Next year will mark the 75th anniversary of the founding of the International Council of Nurses, which was the first international professional organization in the health field. Canada has been a member country since 1909.

ICN executive director Adele Herwitz says the anniversary celebration will be future oriented. "ICN has a proud past and we can take courage and inspiration from what ICN has accomplished. However, nurses in every country are aware of the challenges facing the nursing profession today."

As the international spokesman for nurses, "ICN has a dynamic and growing role," Ms. Herwitz explains. "Through strong national nurses' associations and a strong international federation, nurses are in a position to decide themselves the future of their profession."

Since 1899, ICN has given all countries an incentive to create, improve, and promote professional nursing. It has assumed much responsibility for developing educational standards, and in cooperation with the World Health Organization, has undertaken studies in nursing education. Another achievement has been its development of an international code for nurses. Since 1922, ICN has promoted international exchange programs for nurses.

Included in ICN's plans for observing the 75th anniversary is the production of a special issue of the *International Nursing Review*. ICN publishes this journal quarterly to keep nurses informed about developments in nursing

around the world.

Subscription orders for the *Review* should be sent to ICN, P.O. Box 42, Geneva 20, Switzerland. The price for a one-year subscription is \$9 (U.S.). Payment should be made by personal cheque or international postal money order directly to ICN.

Nurses Employed By N.S. Govt. Accept New Contract Offer

Halifax, N.S. — Following a long contract dispute that culminated September 7 in mass resignations by nursing staff at two government-operated hospitals in Nova Scotia, nurses voted to accept a government offer that came after an all-day Cabinet meeting September 10.

Members of the nursing component of the N.S. Government Employees Association — which includes registered nurses, certified nursing assistants, orderlies, and aides — returned to their jobs at Victoria General Hospital in Halifax and at Nova Scotia Hospital in Dartmouth by September 12. They had been without a contract since last January 1, and had rejected several salary proposals before offering their resignations in August.

#### Correction

In a news story in the September 1973 issue, entitled "Speaker At SRNA Meeting Focuses On Women's Problems In Work World" (page 7), Jean Pipher, president of the Saskatchewan Registered Nurses' Association, was incorrectly referred to as "outgoing president of SRNA" and as "the retiring president."

Ms. Pipher is *not* retiring, although she can be described as outgoing. She still has another year to serve in her two-year term as president. The offer the nurses finally accepted includes a nine percent salary increase in 1973, retroactive to January 1; an eight percent increase effective January 1, 1974; and an across-the-board payment of \$240 to be paid October 1, 1973. The nurses had asked for two payments of \$240, to be spread over two years, to help those at the lower salary levels.

Other benefits in the government offer are four weeks' vacation after five years, and for the first time in Nova Scotia, shift differential and standby pay. The nurses receive a \$1.50 shift differential and \$5 for each eight-hour

shift of standby duty.

In addition, those who resigned were fully reinstated; they only lost pay for the days they were off. The government offer, which also affects some public health nurses, included a withdrawal of arbitration proceedings if the pact were ratified.

Nurses at all four government-run hospitals voted to accept the offer. The other two smaller hospitals were the Nova Scotia Sanatorium in Kentville, which is being phased out, and the Little Flower Hospital in Point Edward.

Registered nurses in all Nova Scotia hospitals received a starting salary of \$6,420 in 1972. Five contracts negociated in private hospitals in the province for 1973 call for an eight percent increase this year and a seven percent

increase next year.

The Registered Nurses' Association of Nova Scotia was fully supportive of the nurses' demands for higher wages and better working conditions. In a statement issued September 6, it deplored the inaction of the government in recent weeks in reaching a satisfactory settlement, and pointed out the association had tried to make it aware of the unrest and low morale generally because of inadequate numbers of staff.

Beginning in the early spring of 1973, an extreme shortage of nurses—estimated as high as 200—existed at the Victoria General Hospital. One of the reasons for this was there were no spring graduates from the school of nursing this year; they are now on the two-year program, which graduates

its students in late August.

On September 7, the RNANS executive made the following statement: "In view of the present dispute between the Civil Service Commission and the Nova Scotia Government Employees Association in the Halifax-Dartmouth area, RNANS recommends that nurses not seek employment with the Civil Service Commission until such time the dispute is settled.

"The Association feels that this is in the interest of patient care and the safe performance of nursing duties, and

(Continued on page 9)

# ofra-tulle vhat's in it

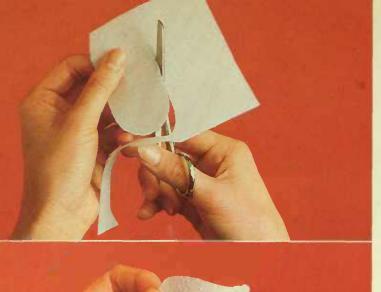
Sofra-Tulle offers you the most effective and convenient antibiotic tulle dressing for wounds, burns and ulcers.

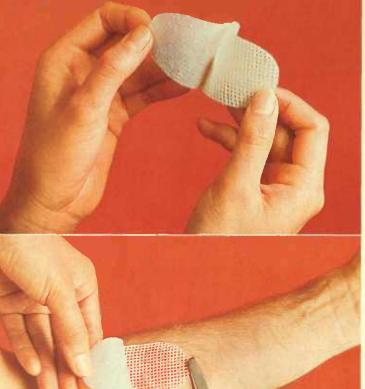
Each Sofra-Tulle dressing sachet is heat-sealed t preserve sterility. Easy to handle, the interleaved tulle can be quickly cut and applied saving valuable time in your crowded day.



# sofra-tulle

single-unit, antibiotic tulle dressing for wounds, burns and ulcers





# sofra-tulle

single-unit, antibiotic tulle dressing for wounds, burns and ulcers

Easy to shape

Each individual dressing is sheathed in sterile parchment for easier handling. Cutting and shaping is neither difficult nor messy with Sofra-Tulle.

#### Clean to handle

The overlapping layers of sterile parchment allow even small pieces to be handled withou touching the tulle itself. In this way the sterility of Sofra-Tulle is maintained up to the moment of use.

Simple to apply

The first layer of parchment is removed before positioning the dressing on the lesion and the second only when the sterile tulle is in place. The lanolin in Sofra-Tulle prevents adhesion and simplifies subsequent dressing changes.

A lightweight lano-paraffin gauze dressing impregnated with 1% Soframycin.

The addition of the antibiotic Soframycin to the paraffin gauze ensures the prevention or eradication of superficial bacterial infections from wounds in a few hours, thereby reducing the need for systemic antibiotics

Soframycin is active against all staphylococci, and against proteus, Ps. pyocynea and the coliform organisms. It is not inactivated by blood, pus or

Soframycin is very soluble in water and mixes very readily with exudates

#### Advantages

Rapid sterilisation of the wound. Excellent mechanical protection.

- No maceration even after three weeks in situ.
- Non-adherent, can be removed painlessly.
- Sensitisation extremely rare

Wounds, burns, ulcers and potentially or secondarily infected skin conditions.

#### Contra-indications

Allergy to lanolin or to Soframycin. Organisms resistant to Soframycin.

If required, the wound may first be cleaned. A single layer of Sofra-Tulle should be applied directly to the wound and covered with an appropriate dressing such as gauze, linen or crepe bandages. In the case of leg ulcers, it is advisable to cut the dressing exactly to the size of the ulcer in order to minimise the risk of sensitisation and not to overlap on the surrounding epidermis. When the infective phase has cleared

the dressing may be changed to a non-impregna one. When the lesion is very exudative it is advisto change the dressing at least once a day.

#### Precautions

In most cases absorption of the antibiotic is so sl that it can be discounted. Where very large b areas are involved (e.g. 30% or more body burn) possibility of ototoxicity and/or nephrotoxicity be produced, should be remembered.

#### Presentation

Sofra-Tulle is presented in cartons of 10 and units, each unit pack containing one sterile a biotic gauze dressing 4" x 4" (10cm x 10cm.)

#### For larger body sites

Sofra-Tulle is also available as tins of a single strip 4" x 40" (10cm x 100cm.)



Full information available on request.

Roussel (Canada) Ltd., 153 Graveline, Montreal 376, Quebec.

#### news

(Continued from page 8)

in the interest of all the nurses of Nova Scotia.

"The association also believes that the nurses have acted responsibly and accountably in their cooperation with the hospital administrations in the establishing of contingency plans for the care of the acutely ill, and feels that no one seriously ill or requiring emergency care service will be denied care.

In addition, the RNANS put an advertisement in the local newspapers to advise RNs considering employment with the Civil Service Commission in the Halifax-Dartmouth area to contact the association beforehand.

Dorothy Miller, RNANS public relations officer, told The Canadian Nurse that both the public and the news media showed almost 100 percent sympathy for the nurses.

During the short walkout, 300 members of the nursing component remained on the job to administer a contingency plan. Those who stayed worked 12 to 13 hours a day. The Victoria General, the largest hospital in the Maritimes, continued to look after emergency and acutely ill patients.

NBARN Report To Guide Nurses **Who Encounter Drug Problems** 

Fredericton, N.B. — An ad hoc committee of the New Brunswick Association of Registered Nurses, which has studied the LeDain report (on the nonmedical use of drugs) on treatment, has released its report. Its primary purpose is to guide nurses who encounter drug problems in institutions and in the community, and to serve as a basis for future involvement of nurses in public education.

The NBARN committee concludes that nommedical drug use is only one aspect of the disturbed behavior exhib-

ited in our society.

"An international restlessness among young people manifests itself in social and political unrest, and a great hunger for spiritual and psychological fulfillment, accounting for widespread experimentation with 'mind-expanding' and 'reality-deadening' drugs....

"The tremendous harm to mental health caused by this situation forces us to look at our ... mental health facilities and to realize they are in no

way able to cope....

The report also concludes that it is not only the young who need special

help. "The problems of the alcoholic and the middle-aged drug-dependent person are just as serious and often more difficult to deal with. These people have existed in our society for many more years than the young drug user, but how many of us can proudly state that our communities are concerned enough about them to have established adequate treatment facilities?"

According to this committee, nurses have a responsibility to:

become aware of and knowledgeable

about drug and alcohol addiction;

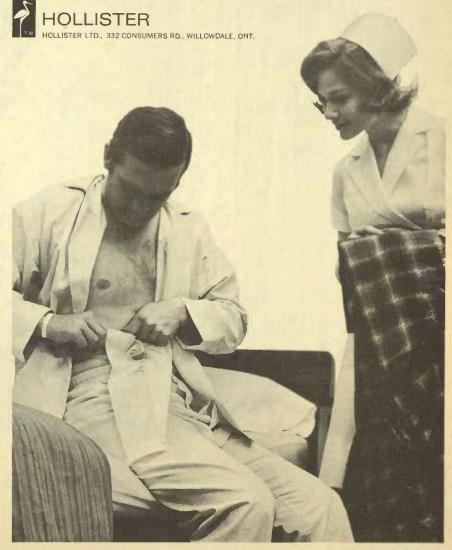
- educate the public, as well as other health workers, about these needs and the community resources available;
- assist in any community social action designed to improve treatment facilities;
- concentrate on the prevention of addiction by treating all persons with dignity and respect, and by referring patients with family, social, or financial problems to sources of genuine help.

(Continued on page 12)

#### Hollister®karaya seal appliances

By preventing skin excoriation and simplifying stoma care, Hollister's Karaya Seal appliances can help speed rehabilitation. Applying one promptly after surgery can prevent excoriation before it starts. The Karaya Ring fits snugly around the stoma, keeping irritating discharge away from the skin. Hollister appliances are disposable, one-piece units. Also available to the patient at authorized pharmacies nationwide. Write for free evaluation kit.

### help your ostomy patient achieve self-care faster

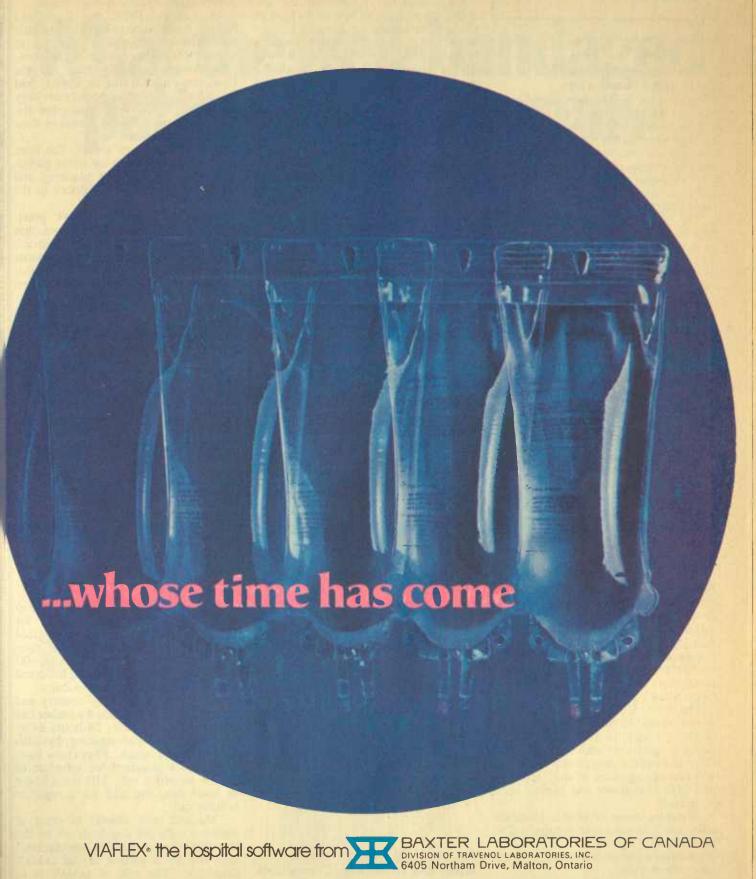


# when you can retire an idea whose time has passed...



you're ready for an idea

it's time for Viaflex
The non-air-dependent shatterproof IV solution container



#### news

Continued from page 9)

CCHA Changes Fee Formula For Hospital Survey Visits

Toronto, Ont. — The Canadian Council on Hospital Accreditation has adopted a new fee formula for hospital accreditation survey visits. The charge is based on the number of surveyors and the amount of time spent in a hospital or extended care facility; the old fee structure based the charge on the rated bed capacity of the hospital.

The basic charge per surveyor-day will be \$325. CCHA believes that for most hospitals of 125 beds or less, and for most extended care centers, the assignment of one surveyor for one day

will be sufficient.

A hospital or extended care facility may request a second surveyor and indicate the desired category, such as doctor, nurse, administrator, or other, and they will be billed accordingly.

The assignment of surveyor-days to units above 300 beds will be decided on CCHA's knowledge from previous records; it will range from three surveyor-days at \$975 for a team of three members for one day, to a three-member team, for three days (nine surveyor-days) for large, sophisticated, and highly specialized hospitals.

The Canadian Nurses' Association obtained a seat on the Council in the fall of 1972; Isobel MacLeod, Montreal, represents CNA on the Council.

(News, October 1972, page 8)

NBARN Invited To Be Represented On N.B. Council On Smoking

Fredericton, N.B. — Following a stand taken against smoking at the annual meeting of the New Brunswick Association of Registered Nurses last May, NBARN has been invited to name representatives to the New Brunswick Council on Smoking and Health.

The council, formed early in 1973, was organized by the provincial department of health to coordinate educational programs on smoking and health. Objectives of the council are to:

• encourage agencies already active in this field to evaluate and expand their programs;

• determine areas of health education best suited to volunteer groups and to governmental agencies;

establish a continuing review of available information;

• find appropriate ways to increase present health education; and

support all legislation directed toward

12 THE CANADIAN NURSE

reducing the health hazards associated with smoking.

Organizations represented on the council, which is the first of its kind in Canada, include the Canadian Cancer Society, the Canadian Heart Foundation, the N.B. Tuberculosis and Respiratory Disease Association, and the Seventh Day Adventists. The provincial departments of education and health also have representation on the Council.

Neurology, Neurosurgery Course Proposed For Working Nurses

Montreal, Que. — The nursing care department of Notre Dame Hospital, in collaboration with the hospital's team of neurosurgeons, has presented the U. of Montreal's department of continuing education with a proposal for a certificate course in neurology and neurosurgery for nurses who are working.

This program, combined with other courses, such as community nursing, could lead to a baccalaureate in nursing, with specialization in neurology or neurosurgery. The only admission requirement would be experience as a

practicing nurse.

According to Madeleine Gerard, chief of inservice education at Notre Dame Hospital, the course, if agreed on, could be set up along the following lines:

• To offer, at the neurological level, a review of anatomy, physiology, pathology, nursing care, pharmacology, and clinical and paraclinical examinations. Preferably, this would include a period of probation in the neurological and related services.

• To teach, during the second part, the techniques of neurosurgery accompanied by instruction in the operating room, followed by a course in neurosurgical care, and ending with a probationary period in neurosurgical services. The clinical portion will be offered by Notre Dame Hospital, as well as by other hospitals.

The initiators of the project believe that courses on legislation and human relations, considered essential to the practice of modern nursing, should be added. These could serve as a basis for

all certificates offered.

A similar certificate program in cardiology is about to be negotiated. According to Ms. Gerard, these programs will not begin before January 1974.

**B.C. Regional Hospital Districts Name RNs To Advisory Committees** 

Vancouver, B.C. — Five regional hospital districts in British Columbia, which have agreed that nursing should

have a voice in planning health facilities and services, have named registered nurses to their advisory committees.

In January 1972, the Registered Nurses' Association of British Columbia requested all 28 regional districts to include RN representation on their hospital boards or committees. At that time, one regional district already had two RNs on its hospital board's advisory committee. Four regional hospital districts have since named nurses to their advisory committees.

For several years RNABC has been emphasizing the need for nurse participation at all levels of planning and coordination of health services in the

province.

Geraldine LaPointe, RNABC president, said the association hopes that in the near future all regional districts will have RNs on their hospital boards or advisory committees. "We want them all to be in a position to benefit from the special skills, technical knowledge, and the awareness of patient needs that registered nurses can contribute to planning for health facilities and services," she said.

Hometown Medical Care Provided Around The World By IAMAT

Toronto, Ont. — The International Association for Medical Assistance to Travellers (IAMAT) aims to make members feel as if they are being treated by their family doctor even while in a foreign country. The acronym IAMAT means to "cure" in Greek. President and founder of the association is Dr. Vincenzo Marcolongo, a Toronto cardiologist.

There is no membership fee to join IAMAT but, since it is a nonprofit organization, tax deductible donations

are welcome.

Members are given a membership card that makes them eligible for IAMAT's services and a pocket-sized directory listing IAMAT centers, their addresses, and phone numbers in 400 cities in 116 countries. The alphabetical list runs from Afghanistan to Zaïre.

The directory lists, by country and city, the centers at which a member can obtain medical care 24-hours-a-day from a qualified, participating physician who speaks English. Physicians have agreed to a standard fee schedule of \$8 for an office call, \$10 for a house or hotel call, and \$15 for a night or holiday call.

"Medical care abroad is often at variance with the standards set by the traveller's home medical association," says the 1973 edition of the IAMAT directory. "The role of IAMAT is to promote a standardization and coordination of medical care available to the

(Continued on page 15)

OCTOBER 1973

# What the well-bandaged patient should wear:

Bandafix is a seamless round-woven elastic "net" bandage, composed of spun latex threads and twined cotton, .

Bandafix has a maximum of elasticity (up to 10-fold) and therefore makes a perfect fixation bandage that never obstructs or causes local pressure on the blood vessels.

Bandafix is not air-tight, because it has large meshes; it causes no skin irritation even when used for the fixation of greasy dressings. The material is completely non-reactive.

Bandafix stays securely in place; there are eight sizes, which if used correctly will provide an excellent fixation bandage for every part of the body.

Bandafix does not change in the presence of blood, pus, serum, urine, water or any liquid met in nursing.

Bandafix saves time when applying, changing and removing bandages; the same bandage may be used several times; it is washable and may be sterilized in an autoclave.

Bandafix is an up-to-date easy-to-use bandage in line with modern efficiency.

Bandafix replaces hydrophilic gauze and adhesive plaster, is very quick to use and has many possibilities of application. It is very suitable for places that otherwise are difficult to bandage.

• Bandafix is economical in use, not only because of its relatively low price but because the same bandage may be used repeatedly.

Bandafix does not fray, because every connection between the latex and cotton threads is knotted; openings of any size may be made with scissors or the fingers.

# **Bandafix**\*

Distributed by

675 Montee de Liesse, Montreal 377, Quebec

New Ductone Vesign MRS. R. F. JOHNSON SUPERVISOR CHARLENE HAYNES MRS. HOLBRUUN ANN COHN, L.P.N.

# ame Pins 'n Things...from Reeves

#### IT'S EASY TO ORDER REEVES NAME PINS FOR YOURSELF OR FRIENDS!

Choose style you want, shown left. Print name (and 2nd line if desired) on dotted lines below. Check other info in boxes on chart, clip this section and attach to coupon

bottom left. Attach extra sheet for additional pins. NOTE SAVINGS DN 2 IDENTICAL PINS . . . more convenient,

2nd LINE: BACKGROUND COLOR (Plastic) PRICES" DESCRIPTION Engraved 1 Line | Engraved 2 Lines ALL METAL . . . rich, trim and tailored. Lightweight, smooth edges, rounded corners. ☐ Gold Duotone Polisher Satin Does ☐ 1 Pin 1.98 ☐ 1 Pin 2.58 ☐ 8lack ☐ 0k. 8lu ☐ White 169 □ Silve 7 2 Pins 3.25 apply PLASTIC LAMINATE . . . slimmer, ☐ White □1 Pin .95 TI Pin 1.45 broader; engraved thru surface contrasting core color. Beveled border matches lettering. Med. Gree Med. Blue 2 Pins 1.65 2 Pins 2.30 (same name) White Letters on apply apply METAL FRAMED ... 1 Pin 1.98 1 Pi 2 Pins 3.25 2 Pi 100 design; snow-white plastic with smooth, polished beveled frame frame MOLDED PLASTIC...Simple, smar economical, Will never discolor. White 1 Pin 95 1 Pi 510 th rounded corners and edges

\*Please add 25, per order for 3 pins or less.

QUANTITY DISCOUNTS: 10-24 pins, deduct 10%; 25-99 pins, 15%; 100 or more pins, 20% 



SCOPE SACK neatly carries and protects Nursescope or any scope. Oouble-thick frosted flexible plastic, white vinyl binding. 4½' x 9½". Your own initials help prevent loss. No. 223 Sack. . . 1.00 ea. 6 or more 75¢ ea. Your initials gold-stamped, add 50¢ per sack.

#### NURSES PERSONALIZED ANEROID SPHYG.

ANLENDID STRITU.

A superb instrument especially designed for nurses! Imported from precision craftsmen in W. Germany, Easy-to-attach Velcro cutfl, lightweight, compact, fits into soft sim. leather zippered case 2½° x² 4′ x 7″. Did calibrated to 320 mm., 10-year accuracy guaranleed to 320 mm., 10-year accuracy guaranleed to 23 mm. Serviced by Reeves if ever required. Your initials engraved on manometer and gold stamped on case FREE, for permanent identification and distinction. A wise investment for a lifetime of dependable service! No. 106 Sphyg. . . . 32.95 ea.



#### CAP ACCESSORIES!

CAP TOTE keeps your caps crisp and clean while stored or carried. Flexible clear plastic, while trim, zipper, carrying strap, hang loop. Stores flet. Also lor wiglets, curlers, etc. 8½" dia., 8" high. No. 333 Tota. 2.65 ea., 6 or more. 2.35 ea. Your initials gold-stamped, add 50¢ per Tote.



WHITE CAP CLIPS Holds caps firmly in place! Hard-to-find white bobbie pins, enamel on fine spring steel. Eight 2" and eight 3" clips included in plastic snap box. No. 529 Clips . . 3 boxes for 1.95, 6 for 3.25, 12 for 49, ea.

(NAI)

#### MOLDED CAP TACS





jewelry-quality Tacs with grippers, holds cap bands securely. Sculptured metal, gold finish, approx. %" wide. Choose RN, LPN, LVN, RN Caduceus or Plain Caduceus. Gift boxed. No. CT-1 (Specify Initials), No. CT-2 (Plain Cad.) or No. CT-3 (RN Cad.) . . . 2.95 pr.

SEL-FIX CAP BAND Black verves band material. Self-adhasive, presses on, pulls off, no sewing or pinning. Reusable several times. Each band 20" long, pre-cut to popular widths: ½" (12 per plastic box) ½" (8 per box) ½" (6 per box) ½ SEL-FIX CAP BAND Black velvet



	TH KEEAES	S CUMPANY, BOX	G , At	tiebori	o, mass	5. UZ/U3	
	ORDER NO.	ITEM	COLOR	SIZE	QUANT.	PRICE	
į							
ĺ	Use extra sheet for additional items or orders.						
	INITIALS as	desired:					

(Mass, residents add 3% S. T.) Sorry, no COD's or billing terms evailable Send to .....

TO ORDER NAME PINS, fill out all information in box top right, clip out and attach to this coupon.

(Good idea . . . for distinctive identification)

13.80 ea. ppd. 6-11...12.80 ea. 12 or more...11.80 ea. Group Discounts include free Initials and Sack!

MEDI-CARD SET Handiest reference ever! 6 smooth plastic cards (3½ " x 5½") crammed with information, including Equivalencies of Apothecary to Metric to Household Meas, Temp. "C to "F, Prascrip. Abbr., Urinalysis, Body Chem., Blood Chem., Liver Tests, Bone Marrow, Oisease Incub. Periods, Adult Wgts., Child's Dosages, etc. All in white viryl holder with gold stamped caduceus. No. 289 Card Set . . . -1.50 ea. 6 or more 1.25 ea. 12 or more 1.10 ea. Your inItials gold-stamped on holder, add 50¢ per set.



KELLY FORCEPS So handy for every nurse! 5½" stainless steel, fully guaranteed. Ideal for clamping off tubing. Your own initials help prevent loss.

CAR No. 25-72 Forceps . . . 2.75 ea. 6 or more 2.50 ea. Your initials engraved, add 50¢ per forceps.



#### Free Initials and Scope Sack with your own Littmann Nursescope!



No. 216 Nursescope.

Famous Littmann nurses' Famous Littmann nurses' diaphragm stethoscope ... a fine precision instrument, with high sensitivity for blood pressures, apical pulse rate. Only 2 ozs., fits in pocket, with gray vinyl anticollapse tubing, non-chilling epoxy diaphragm. 28" overall. Non-rotating angled ear tubes and chest piece beautubes and chest piece beau-tifully styled in choice of 5 jewel-like colors: Goldtone, Silvertone, Blue, Green, Pink.\*

FREE INITIALS AND SACK! Your initials engraved FREE on chest piece; lend individ-ual distinction and help pre-vent loss. Also FREE SCOPE SACK included, worth \$1. as described above right. (Free sacks not personalized; add 50¢ if initials desired.) Ideal for group gifts! Note big savings on quantity orders (left).

\*IMPORTANT NEW FEATURE: New "Medallion" styling includes tubing in colors to match metal parts. If desired, please add \$1. ea. to all prices above, and add "M" to Order No. (No. 216M) on coupon. Duty free

SCISSORS Precision-made imported forged steel.
Professional quality. Guaranteed 2 years.



31/2" LISTER MINI-SCISSORS Tiny, handy, slip into uniform pocket or purse Choose jewelers Gold or glearning Chrome plate linish on coupon No. 3500 Mini-Scissors . . . 2.75 ea.

41/2" or 51/2" LISTER SCISSORS above, but larger for bigger jobs. Chrome finish only No. 4500 (41/2") or No. 5500 (51/2") Scissors . . . 2.75

51/2" OPERATING SCISSORS Stainless steel, with sharp/blunt points. Beautifully polished linish. No. 705 OR Scissors . . . 2.75 ea.

All scissors above: 1 doz. or more lany style) . . . 2.00 ea.
Your initials engraved, add 50c per scissors.

CLAYTON DUAL STETHOSCOPE Light weight imported dual scope; highest sensitivity for pulse rate. Chromed head tubes and chest piece wil 1½" bell and 1½" diaphragm, grey arti-collapse tubing, 4 oz., 29" long. Extra ear plugs and diaphragm included. Iwo initials engraved free. (CD) Duty free No. 413 Dual Steth . . . . . . . 17.95 ea.

JEWELRY

NURSES CHARMS

Finest sculptured Fisher charms, Sterling or Gold Filled (specify under COLOR on coupon) For bracelet or pendant chain. Add to your collection! No. 263 Caduceus; No. 164 Cap; No. 68 Grad, Hat; No. 8, Band, Scissors . . 3.49 ea.



14K PIERCED EARRINGS Dainty, detailed 14K Gold styles, for on or off duty wear. Shown actual size. Beautifully gift boxed.

fully gift boxed.

Birthstone Colors (specify on coupon): JAN Garnet, FEB Amethyst, MAR Aqua, APR Crystal, MAY Emerald, JUNE Alexandrite, JULY Ruby, AUG Peridot, SEPT Sapphire, OCT Rose Zircon, NOV Topaz, OEC Blue Zircon.

No. 13/297 Caduceus; No. 13/278 Cross; \$5.95 per pair.

No. 1/010 Sen. Cultured Pearl; No. 8/247 Birthstone

PIN GUARD Sculptured caduceus: chained to your professional letters, each with pinback/ safety catch. Or replace either with class pin for safety. Gold finish, gift boxed. Choose RN, LPN or LVN. No. 3420 Pin Guard . . . . . 2.95 ea.



ENAMELED PINS Beautifully sculptured status Insignia, 2-color keyed, hard-fired enamel on gold plate. Dime-sized, pin-back. Specify RN, LPN, PN, LVN, NA, or RPh. on coupon.

No. 205 Enam. Pin 1.35 ea., 12 or more 1.50 ea.





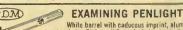
No. 791 (left) Onluxe Saver, 3 compt. change pocket & key chain . . . 6 for 2.98, 25 or more 35 € ea.



No. 291 Pal Kit . . . . . . . 4.95 ea 3 Initials engraved on shears, add 50¢ per kit.

BZZZ MEMO-TIMER Time hot packs, heat lamps, park meters. Remember to check vital signs, give medication, etc. Lightweight, compact (1½" dia.l., sets to buzz 5 to 60 min. Key zing. Swiss made. No. M-22 Timer , . . . . . 4.95 ea. 3 or more 3.95 ea.; 6 or more 3.50 ea





White barrel with caduceus imprint, aluminum band and clip. 5" long, U.S. made, batteries included (replacement batteries available any store). Your own light, gift boxed. No. 007 Penlight . . . 3.98 ca. Your Initials engraved, add 50g per light

# Uniform Fashions Reeves



#### **PANTAMEROUS**

Ultra-fashion pants suit with form-fitting "L" darts. Generous fashion puff pockets. Front opening. New "No-Trip" cuffs reduce hazard of catching heel . . . and easy to alter, too. Inner surgical pocket. 34 Steeves.

STYLE No. 4628 100% Dacron Polyester Double Knrt

SIZES: 4-18 31.95 (set) ppd.

#### GIBSON GIRL

Youthful high-rise waist, soft shirred skirt, pleated blouse. Inner surgical pocket. Mini length.

STYLE No. 4624 100% Polyester Warp Knit; 34 Sleeves.

SIZES: 3/4-15/16 18.95 ppd.

STYLE No. 4824 6D% Dacron Polyester, 40% Nylon Cord Jersey. Short Sleeves.

SIZES: 3/4-15/16 15.95 ppd,



#### TUCK-HI

Chinese square mandarin, with milti-tuck front yoke, smartly accented with buttons on front flange, back zipper. A different style for today's nurse.

34 Sleeves. 80% Dacron Polyester, 20% Cotton Super Faille.

STYLE No. 4726 SIZES: 8-20 17.95 ppd. STYLE No. 5726

SIZES: 4-14 Petite 17.95 ppd.



Unique smock style in a professional uniform . . . for soft feminine appeal.

Large generous patch

pockets and inner surgical pocket. Short Sleeves. 100% Dacron Polyester Double Knit "Crystalon". A little girl look at the top of fashion.

STYLE No. 4632 SIZES: 3/4 - 15/16 21.95 ppd.



#### news

(Continued from page 12)

traveller abroad." Membership privileges do not apply to travel in the member's own country.

IAMAT's head office is in New York City; there is a European office in Switzerland and a Canadian office in Toronto.

For membership, write to IAMAT, 1268 St. Clair Ave. West, Toronto, Ontario M6E 1B9.

#### Nurses In Great Britain Protest Proposed Salaries In National Health Service

London, England — British nurses have been reacting with outrage to the proposed salaries for chief nursing officers in the reorganized National Health Service (NHS).

Last July 12, Nursing Times reported that Mary Blakeley, OBE, joined the mounting protest. She resigned as a member of the panel of assessors for the regional nursing officers because she "couldn't go along with the assessments [of] these salaries." Ms. Blakeley, who is considered a leading member of the nursing profession, was president of the Royal College of Nurses until October 1972.

Interim salary scales for the top nurses in the NHS were announced in May 1973 by Sir Keith Joseph, secretary of state for social services, following the breakdown of negotiations with the Nurses and Midwives Whitley Council.

In its May 31 editorial, *Nursing Times* explained: "Because the staff and management sides of the various Whitley Councils have failed to reach agreement on suitable salary scales for chief officers in the new NHS, and because Sir Keith is anxious that the timetable of appointments for reorganization should not be altered, he has taken unilateral action and published salary scales he would be prepared to approve so that appointments can be ... made in the autumn."

By doing this, the editorial said, "he has ignored the most important element in the nursing profession's case — the question of equality in the new management teams."

The new salary scale for regional nursing officers in the reorganized NHS is supposed to take into account their new responsibilities as full members of the management team, which also includes administrative and finance officers, and doctors. But as *Nursing Times* 

noted in a June 7 editorial, if salary scales are any guide, nurses come a poor fourth on this team.

"The difference between the maximum salary of a top nursing officer and a top administrator is a cool 2,700 pounds (approximately \$6,850)," Nursing Times reports. It also points out that "a regional nursing officer at the top of the scale will be earning over 1,000 pounds (\$2,540) less than the lowest paid regional administrators." A regional administrator will get a maximum of 9,249 pounds (\$23,490), compared with a maximum of 6,550 pounds (\$16,635) for a regional nursing officer.

Criticism of the proposed salaries is also aimed at the inequalities they would create within the nursing profession. According to a news report in the May 31 issue of *Nursing Times*, "the top salary for a regional nursing officer (6,549 pounds) is over 1,000 pounds more than the top salary for a district officer in a large district (5,256 pounds).

"It is felt that although different skills may be necessary to administer a district than an area or region, the difference is not one which should be reflected by such great disparities in salary," the report adds.

Another point of contention is that Sir Keith Joseph has not taken unilateral action with regard to doctors' salaries, which are expected to begin well above 10,000 pounds (\$25,400).

The new salaries are to be reviewed by April 1, 1975, at the latest.

#### Children's Hospital Opens Units For Patients And Their Mothers

Toronto, Ont. — With the opening of two new facilities at The Hospital for Sick Children in September 1973, mothers of hospitalized children can now live at the hospital and learn to care for their children.

One of these facilities is a hostel unit, located on the sixth floor of the nurses' residence adjoining the hospital. This unit accommodates 26 mothers, most of whom are expected to come from outside Toronto and even from other countries. Cost of the accommodation is \$5 a day or \$30 a week.

The other new facility, called the care-by-parent unit, can accommodate 14 ambulatory patients and their mothers. Two categories of patients receive care in this unit: those who require extensive tests or treatment but not continous medical care, and those who are ready for release from hospital as soon as their families are trained in home-care procedures.

In the care-by-parent unit, young children share a room with their moth-

(Continued on page 16)

#### news

(Continued from page 15)

ers, and older children have their own room. In both cases, mothers are responsible for their children's personal hygiene and for making sure the rooms are tidy, the beds made, and the patients in bed at a reasonable time.

These mothers learn to care for their children who have tracheotomy tubes and pacemakers, and accompany them to tests and therapy sessions. A receptionist is on duty on the unit from 8:00 A.M. to 8:00 P.M., and a telephone gives them direct "hot-line" contact with the emergency department.

Residents in both units have access to a lounge with books and television and to a kitchen well stocked with basic supplies, such as coffee, cookies, and peanut butter. Toys are also provided

for the young patients.

A preliminary hospital survey of parents who had children eligible for the care-by-parent unit indicated the parents were enthusiastic about the plan. Letters were sent to 154 mothers to see if they were interested in participating. Of the 85 replies received, 73 of the mothers were in favor of living in with their child.

Community Health Center Opens In High-Rise Apartment Complex

Toronto, Ont. — Since last August 14, more than 8,000 tenants in mid-Toronto have had access to on-the-spot health care. They live in the St. James Town high-rise apartment complex, where a community health center is operating as an extension of the family practice unit of The Weilesley Hospital.

The need for the health center is greatest among the 3,000 tenants who live in the four apartment buildings operated on a "rent-geared-to-income" basis by the Ontario Housing Corporation. More than 1,100 of these tenants are elderly and disabled. For them, the center is especially well located — on the ground floor of one OHC building.

Dr. Irwin Bean, director of the center and family physician-in-chief at The Wellesley Hospital, calls the center "the best example of community self-help

I've ever seen."

It was the tenants' association in one of the OHC buildings that took the first step by approaching the St. James Town management. Both groups then met with officials from The Wellesley, which is across the street from St. James Town. Cooperation also came from the Ontario and federal departments

of health, the OHC, and the University of Toronto.

Ample space for the health center was acquired by combining two family-sized apartments. The center consists of reception and waiting rooms, rooms for examination and ambulatory treatment, staff offices and lounge. In addition, the St. James Town branch of the YMCA is making exercise rooms available as part of a preventative and therapeutic rehabilitation program.

The Emergency Help Service of St. James Town, which a group of tenant volunteers organized to help disabled residents, has been integrated within the health center. Before the center opened, this service helped residents by making meals, cleaning, and taking them to the doctor.

At present, the staff includes two doctors, two registered nurses, a public health nurse, and a social worker. They are backed up by the consultant and supportive services of the hospital.

Two Wellesley nurses, Gene Gunn and Shirley Heard, planned the center and hired staff. Ms. Gunn is director of outpatient clinics, and Ms. Heard is clinical coordinator of the department.

Patients' Representative Humanizes Hospital Stay

Montreal, Que. — One of the main purposes for a patient relations representative at the Jewish General Hospital is to humanize the patient's hospital experience. The first patient relations representative (ombudsman) in Canada is Peggy Lahaie, who began the work in February 1973.

Another purpose of the position is

It's Winnipeg In '74



The Gateway to the West swings both ways — join nurses from across Canada at CNA's annual meeting and convention in Winnipeg, June 16 to 21, 1974. There is murky water (Cree meaning of Winnipeg) at the juncture of the Assiniboine and Red Rivers, but if you can see your way clear to come, you'll have a "buffalo of a time!" (No whales in the Red River!)

to provide an individual to act as the patient's friend from the time of his admission until his discharge. The ombudsman interprets the purpose and philosophies of the hospital to the patient and the patient's problems and opinions to the hospital administration. She also explains the patient's needs to hospital administration and staff.

The patient ombudsman is responsible to the hospital administration through the medical director, to whom she reports daily. Her salary is paid from funds supplied for the purpose

by the women's auxiliary.

A questionnaire, sent to patients after their discharge, asks whether the individual felt the nursing staff were interested in him as a person, were prompt and courteous in responding to his requests, and whether the schedule was arranged to allow him adequate rest. Other questions concern meals; volunteers; admitting procedure; TV, tefephone, mail, and flower service; x-ray; and laboratory.

The returned questionnaires are reviewed by the patient relations representative. The compiled results of the questionnaires are shared with the assistant director of nursing service. The ombudsman communicates directly with the head nurses in many instances, but she maintains a liaison

with the assistant director.

Patients are made aware of the ombudsman's services by a booklet on the bedside table, explaining how the patient or his family can contact the patient relations representative, and a sticker on the telephone, giving the telephone number and location of the ombudsman.

Among the ombudsman's chief responsibilities is to receive and rectify complaints. She interviews the patient and discusses the situation, investigates the complaint, and initiate's action or change to correct the situation. She tries to handle all problems on the lowest possible level of the organization.

She follows up the action and reports to the patient what corrective measures are, were, or will be taken. She also keeps a record of complaints, compliments, and services given. In this way she is aware of trends developing it specific areas. She implements ideas for improvement and discusses these with the director or division head involved.

Helen Taylor, director of nursing service at the Jewish General Hospital, told *The Canadian Nurse:* "The twoway communication between the ombudsman and members of the nursing staff at all levels has been open and objective."

Ms. Lahaie was public relations director of a Montreal hotel before becoming the Jewish General's patient relations representative.

# Saunders

# Saunders

#### for a better reflection of nursing progress

#### Spencer: PATIENT CARE IN ENDOCRINE **PROBLEMS**

A comprehensive, clinically oriented text for nursing care in diseases and disorders of the endocrine system. Reviews physiology and pathophysiology of each endocrine organ and discusses its diseases, treatment and nursing care. A case study, or "patient portrait," is included for each organ. By Roberta T. Spencer, R.N., M.S.N.E. 230 pp. Illustd. \$10.05. January 1973.

#### Watson: MEDICAL-SURGICAL NURSING AND RELATED PHYSIOLOGY

The physiologic basis of patient care is discussed in the 27 clearly written and concise chapters found in this exceptional text. The author reviews the relevant anatomy, physiology, and pathophysiology-and, on that basis, sets forth the rationale and goals of effective treatment and nursing. Extensive cross-references lead the reader to relevant ancillary discussions. The nearly 100 illustrations are of unusual instructional quality and visual appeal. By Jeannette E. Watson. R.N., M.Sc.N. 786 pp. Illustd. \$10.30. April 1972.

#### Stryker: REHABILITATIVE ASPECTS OF ACUTE AND CHRONIC NURSING CARE

This book has been specifically designed to help you implement rehabilitative steps in acute and long-term care as well as restorative care of the chronically ill and disabled. The author presents discussions which relate particularly to problems associated with neuromuscular and skeletal conditions, and to principles, components, and applications of rehabilitative measures. By Ruth P. Stryker, R.N., M.A. 236 pp. 125 ills. \$8.00. April 1972.

#### Harrington & Brener: PATIENT CARE IN RENAL FAILURE

A thorough guide to treatment of patients with kidney disorders. The authors review basic anatomy and physiology-including fluid and electrolyte balance-and build to a detailed coverage of practical methods of nursing care. They describe treatment by hemodialysis, peritoneal dialysis, transplantation, and conservative methods of correcting renal failure. Lastly, they look into the prevention and control of renal diseases. By Joan D. Harrington, R.N., B.S.N., M.A.; and Etta Rae Brener, R.N., B.S.N., M.Ed. About 305 pp. Illustd. About \$10.05. Just Ready.

#### Robinson: **PSYCHIATRIC NURSING AS** A HUMAN EXPERIENCE

Emphasizing the human qualities so necessary in psychiatric nursing, this text provides you with an understanding of how to cope with and creatively respond to a patient's problems and anxieties. The nurse is depicted encountering patients with psychological problems in a variety of settings—individual psychotherapy; community work; family, group, and institutional therapy. Intervention through environmental manipulation, behavior modifications, and remotivation are fully discussed. By Lisa Robinson, R.N., Ph.D. 352 pp. \$8.25. September 1972.

#### Bermosk & Corsini: CRITICAL INCIDENTS IN NURSING

Illuminates common human-relations problems which confront today's nurse. From euthanasia to a professional disagreement with a doctor, each of 38 incidents is scrutinized by a panel of specialists who voice their opinions on how to approach the problem ethically and with professionalism. Provides a beneficial learning experience for any nurse. By Loretta Sue Bermosk, R.N., M. Litt.; and Raymond J. Corsini, Ph.D. 369 pp. \$11.85. June 1973.

-	K
-	

#### W.B. SAUNDERS COMPANY CANADA, LIMITED 33 Oxford Street, Toronto 18

□ 85 □ 91	send and $\square$ bill me $\square$ send postpaid—check 17 Spencer: Endocrine Problems \$10.05. 35 Watson: Medical-Surgical Nursing \$10.30. 38 Stryker: Rehabilitative Aspects \$8.00.	enclosed  4528 Harrington & Brener: Renal Failure About \$10.05  7620 Robinson: Psychiatric Nursing \$8.25.  1696 Bermosk & Corsini: Critical Incidents \$11.85.	
Name		Address	
	Prov.	<b>Zone</b> CN 10-	73



# UROGATE\* The total system to meet all your irrigating requirements

Solutions
Administration sets
Drainbox\*\*

Now with the Urogate System you can choose from four handy big-mouth bottles.

You'll like the new 500 ml. and 1,000 ml. sizes. They're just right when you need smaller volumes of pour solutions.

Or, where you need *larger* volumes, the familiar 1,500 ml. and 3,000 ml. Urogate containers are ideal.

Those generous 38-mm. openings are built for business! For example, you can empty the new 1,000 ml. bottle in 10 seconds. Or empty the 500 ml. bottle in just 7 seconds.

(Or, when you choose, pour a slow, carefully regulated stream.)

No mix-up with I.V. bottles on your shelf either: you can recognize the distinctive Urogate shape at a glance. What's more, these bottles accept only Urogate urologic sets. No chance of accidental intravenous infusion.

You'll find a choice of Urogate solutions and sets for all your surgical and urologic irrigating needs. It will be worth your while to learn the details. Why not talk to your Abbott Representative this week.

## **Urogate**



## new products

Descriptions are based on information supplied by the manufacturer. No endorsement is intended.



DualPeel Pouches

**DualPeel** pouches

DualPeel pouches from Tower Products, Inc. can be either gas or steam sterilized; both process indicators are on each pouch. The peel-open feature allows quick aseptic presentation in operating rooms.

The paper/plastic pouches allow items to be identified easily through the clear plastic side. The surgical-grade-paper side allows thorough sterilization, prevents costly bag failure, and minimizes fiber tearing or shredding.

According to the company, DualPeel pouches are ideal for sterile surgical items requiring aseptic presentation and low cost breathable packaging.

For further information and a free sample, write to Tower Products, Inc., 1919 S. Butterfield Road, Mundelein, Illinois 60060, U.S.A.

IVAC 500 infusion pump

All standard IV setups and tubing can be used with the IVAC 500 infusion pump, which ensures positive flow and adjusts to and maintains the prescribed rate. It cannot infuse air, and if the bottle runs out of fluid, the pump will go into alarm and will shut off automatically.

According to IVAC Corporation, this product is ideal for Pitocin administration and viscous IV solutions, and is a necessity for obstetric and pediatric departments.

For additional information, write to Sterimed, division of SteriSystems Ltd., 47 Baywood Road, Rexdale, Ontario.



Infusion Pump

Antibiotic for vaginitis

Vanobid, introduced by the Wm. S. Merrell Company, is a new antifungal antibiotic for treating vaginitis due to *Candida Albicans* and other *Candida* species.

Vanobid is available as a vaginal ointment or a vaginal tablet. According to the company, B.I.D. treatments for 14 days have established microbiological cure rates of approximately 80 percent, and 90 percent after a second course of therapy in difficult cases.

For more information, write to the William S. Merrell Co., 2 Norelco Drive, Weston, Ontario.

Welder's Eye-Ease

Safeco Welder's Eye-Ease is now made in Canada. It is recommended for the relief of discomfort caused by flash burns from welding or arcing equipment, sun and snow blindness, and minor irritations caused by wind and dust.

This liquid immediately spreads over the affected surface to give quick and effective relief for conditions that result from exposure of the eye to ultraviolet or infrared rays of the welder's arc. It is bottled in a convenient new one-ounce, self-dripping, plastic bottle, which eliminates a glass dropper.

Welder's Eye-Ease is available from Safety Supply Company, 214 King Street East, Toronto, Ontario.

#### retal heart monitor

The Fairfield Fetone "M" fetal heart monitor operates directly from the AC power supply, always ready for immediate use. It is available with the following alternative transducers:

• directional transducer for use in diagnosis throughout pregnancy;

• wide-angle transducer for audio monitoring during labor;

• early fetal pulse detection (10 to 12 weeks);

• viable fetus confirmation;

• placental localization (24 to 26 weeks); and

• battery-powered unit.

More information can be obtained from Sterimed, division of SteriSystems Ltd., 47 Baywood Road, Rexdale, Ontario.

(Continued on page 23)

# The Gentle Ones

Minimize trauma to sensitive mucosa with the Gentle Ones — Davol's unexcelled quality 22", 20", 18" and 16" rubber suction catheters. Made of soft, gentle, X-ray opaque red latex, with specially formed tips.

But don't be fooled. The Gentle Ones are also strong. With properly proportioned eyes for aspirating thick, tenacious exudate. Sturdy, tull-flared funnels to allow quick, positive connections to suction tubing. Control valves for manual control of suction, raised to prevent finger contamination by the exudate. And strong, pliable, uniformly smooth surfaces to make insertion easy.

Davol single-use latex catheters are now available in a greater choice of lengths and French sizes; there's a new 22" catheter with control vent to complete the line.

And they come sterile in individual see-through, peel-back packages.

DAVOL

So make a point to ask your Davol Dealer

Salesman about the Gentle Ones. Davol
Canada Ltd., 1033 Range View Road, Port Credit.
Ontario L5E-1H2. Phone: (416) 274-5252.



### COCKTAIL FOR ONE

Why not have the "black and white cocktail" served in your hospital in the Patient Cup™? The wide-mouth opening of this liquid unit dose container makes it easy for the patient to drink ORGANON'S smooth suspension of Milk of Magnesia and Cascara. (It's pleasant tasting, too.)

Each Patient Cup delivers a stable, precise dose of Magnesium Hydroxide (8%) equivalent to 30 ml. Milk of Magnesia U.S.P., and Cascara Extract equivalent to 5 ml. Aromatic Cascara Fluid extract U.S.P. Alcohol 3.5%.

No mixing. No pouring. No waste. Here is another opportunity for your pharmacy to extend its control of medication right up to the administration of a single dose. And, you'll make some more friends in the nursing department as well.

Order several shippers of Milk of Magnesia-Cascara Suspension. There are 100 doses in each, packed 10 to the shelf tray.

Set 'em up!



The Patient Cup



ORGANON CANADA LTD/LTÉE

INTRA MEDICAL PRODUCTS DIVISION TORONTO, CANADA

#### new products

(Continued from page 20)

Latex procedure gloves

New disposable latex procedure gloves for uses ranging from catheterization to emergency room procedures are being marketed by Perry, a division of Affiliated Hospital Products. The sterile gloves are .003 to .004 inches thick, which gives a natural feel, and have tapered fingers to prevent wrinkling and assure better sensitivity.

The gloves, made from surgical latex, are beaded to keep them in place; the beading, combined with a minimum of powder, makes them easter to put on. They come in small, medium, and large sizes, and are packed 25 pairs per box. Each pair comes in a small, peel-down package, which is cold sealed to eliminate contamination from frayed edges.

For more information and samples, write to Affiliated Medical Products Limited, 90 Commercial Ave., Ajax, Ontario.

#### Literature available

Medtronic, Inc., Minneapolis, Minnesota, has published a colorfully-illustrated manual entitled "An Overview of Pacing" in its *Currents* series.

The overview gives a brief look at the structure and function of the heart and circulatory system; the mechanism of response of a muscle cell to a stimulus, resulting in contraction; the normal cycle of events that occurs with each heartbeat. It also discusses the way the heart normally controls its own rhythm, and the failure of this control, requiring an artificial pacemaker; the basics of pacemaker circuit operation, and the types of pacemaker circuit and pacing electrode available; and pacemaker implantation and patient management.

Information about obtaining this 74page manual is available from Medtronic of Canada Ltd., 5925 Monkland Avenue, Montreal, Que.

Clin-Alert, a \$25 per year subscription service for health care professionals, provides current information on adverse drug reactions, drug interactions, and

related therapeutic hazards.

Clin-Alert mails up to 30 bulletins annually on pertinent reports of adverse drug reactions digested from medical literature originally published throughout the world. A perpetual updating is accomplished by the continual monitoring of some 150 leading medical journals published on five continents. Each bulletin contains about a dozen sum-

maries and is rushed to subscribers in 40 countries.

Quarterly cumulative indexes and a special binder are provided; in addition, a Clin-Alert 10-Year (1962-1971) Cumulative Index and back issues from 1962 are available.

Write to Clin-Alert, Science Editors, Inc., P.O. Box 7185, Louisville, Kentucky 40207, U.S.A.

A new color brochure, entitled *The Sound Way to Cleaner Instruments*, is available from Castle Company, a division of Sybron Corporation.

The six-page color brochure discusses the features of four of Castle's sonic cleaners, with a description of how sonic energy is used in cleaning medical instruments. It describes Castle's three-compartment sonic cleaner, which features separate clean, rinse, and dry chambers, and cuts processing time in half. Also mentioned is Castle's sonic sink for light loads, automatic conveyor sonic cleaner for use in the medium to large hospital, and an explanation of Castle's complete instrument processing system.

Write to Castle Company, 1777 E. Henrietta Rd., Rochester, New York, 14623, U.S.A.

A 12-page illustrated bulletin (no. 480-3) describes the Gould 9500 Computerized Monitoring System, which combines arrhythmia monitoring, patient data processing, and ECG analysis/printout in a single, hospital-oriented system.

A highlight of the Gould 9500 system is a minicomputer, which, for arrhythmia monitoring, continuously analyzes ECG signals from up to 16 acute care patients. Special programming establishes a "reference" ECG from each patient's individual heartbeat, and any ectopic beats actuate automatic alarms.

The Gould 9500 shows ease and flexibility of entering, retrieving, and displaying vital patient data. This capability, extending from admission to discharge from acute care units, eliminates the need for nurses to prepare handwritten notes. A nurse can learn to operate the Gould 9500 in less than an hour, since the system involves no unfamiliar computer language or specialized techniques.

Detailed patient information, such as alarm limits, trend curves, notes, and lab tests, can be easily called up from the system's index page display. Also, printed summary reports on each patient are automatically produced on demand every 24 hours and when the patient is discharged.

The bulletin is available from Marketing Services, Gould Inc., Instrument Systems Division, 3631 Perkins Ave., Cleveland, Ohio 44114, U.S.A.



What no hospita bed should be without, a Decubinix® bed pad.

- 1/4" thicker than the next best pad.
- · Fire resistant.
- Higher degree of absorbency.
- Can be laundered two or three times.
- Autoclaveable.
- May be cut to any desired size or shape.

	MAIL THIS COUPON TODAY FOR A COMPLETE CATALOGUE.
	Scholl   HOSPITAL PRODUCTS DIVISION
	Scholl (Canada) Inc. HOSPITAL PRODUCTS DIVISION 174 Bartley Drive Toronto 16, Ontario
İ	NAME
į	TITLE
İ	HOSPITAL
i	ADDRESS
-	CITYPROV

#### names



Margaret McCrady





Margaret Nugent

New appointments to the staft of the Health Sciences Centre of Winnipeg have been announced: Margaret Mc-Crady, as assistant to the vice-president, nursing; E. Margaret Nugent, director, nursing of adults; Richard Paterson, director, administrative services (nursing), and administrative assistant of children's services; Pat Scorer, director, nursing of children; and Doris Setter, associate director, nursing of adults.

Ms. McCrady graduated as a nurse from the Winnipeg General Hospital School of Nursing, earned her B.N. at the University of Manitoba, and as a CNF scholar, an M.Sc.N. at the University of Western Ontario, London. Except for two tours of duty in hospitals in New Haven, Conn., and Thunder Bay, Ont., Ms. McCrady's career has been largely devoted to teaching in hospital schools of nursing in Winnipeg.



Richard Paterson



Pat Scorer

Ms. Nugent (R.N., Winnipeg General Hospital School of Nursing; B.A., U. of Manitoba; M.A. (nurs. educ.), Columbia U.), prior to her present appointment, was director of nursing service at the Winnipeg General Hospital. Ms. Nugent, a past president of the Manitoba Association of Registered Nurses, is a member of the board of the Canadian Nurses' Foundation and of the advisory council, Manitoba division of the St. John Ambulance Association.

Mr. Paterson (B.A., U. of Manitoba; M.H.S.A., U. of Alberta) was, early

in his career, a certified nursing assistant, and later a registered x-ray technician. Since 1970, he has held hospital and related administrative appointments

in Winnipeg.

Ms. Scorer (R.N., Children's Hospital School of Nursing, Winnipeg; B.Sc. N., U. of Manitoba) has been director of nursing, Children's Hospital, Winnipeg, since 1962, before which she had been assistant director of nursing. Earlier in her career, Ms. Scorer nursed at Oakland Children's Hospital and was head nurse, tuberculosis and chest surgery, at the University of Texas.

Ms. Setter (R.N., Misericordia General Hospital School of Nursing, Winnipeg; Cert. rehabilitation nursing, Rehabilitation Institute, Detroit, Mich.; Cert. respiratory disease nursing, U. of Minnesota, Minneapolis) was a nursing



sister with the Royal Canadian Navy during World War II, has worked with an internist in London, Ontario, and has been on the staff of the Victorian Order of Nurses in Montreal, nurs-

ing director of the health department of the Town of Mount Royal, and school nurse in St. Bruno, Quebec. She came to the Manitoba Rehabilitation Hospital in 1963 to teach rehabilitation nursing and held various positions there before becoming director of nursing services.

Frances Sikora succeeds Joan Monier-Williams as nurse director of the Ottawa branch of the Canadian Mothercraft Society

Ms. Sikora (R.N., University Hospital School of Nursing, Edmonton; B.N., McGill University, Montreal) is currently working toward a master of education degree at the University of Ottawa. Her nursing career has included health nursing in a home for unmarried mothers in Edmonton, and the positions of lecturer, educational director, and assistant director of the school of nursing, St. Joseph's Hospital, Peterborough.

Ms. Sikora has also been involved in volunteer programs promoting community health and education, and in Peterborough's United Community Services as a council member.

Shirley Savoie is the new director of nursing services, Shuswap Lake General Hospital, Salmon Arm, B.C.

In the interval between carning her R.N. at Hotel Dieu Hospital school of nursing, Moncton, N.B., and her B.S.N. at Seattle University, Seattle, Washington, Ms. Savoie's nursing career has brought her to the Providence Hospital, High Prairie, Alberta, as staff nurse; to Notre Dame Hospital, North Battleford, Saskatchewan, as supervisor; and to St. Joseph's General Hospital, Dawson Creek, B.C., as supervisor, then director of nursing.

Prior to her current appointment, Ms. Savoie has been nursing care coordinator at the Misericordia Hospital,

Edmonton, Alberta.

Shirley M. Stinson, has been named graduate program coordinator for the school of nursing, University of Alberta, Edmonton. She will direct the new masters in nursing program in Nursing in Acute Illness, the first clinical nursing program aimed at acute illness as a specialty area.

While students' specialized clinical interests (such as medical-surgical, maternal child health, and/or psychiatric nursing) will be regarded in planning their programs, primary emphasis will be on preparing graduates to nurse the acutely ill, whatever their clinical category. The curriculum allows students to take part of their course work, such as research design and statistics, in the division of health services administration along with other health professionals.

Dr. Stinson (B.Sc., U. of Alberta; M.N.A., U. of Minnesota; Ed.D., Columbia U.) was a 1973 recipient of a senior national health research scientist award. She has held a dual appointment as professor in the school of nursing and the division of health services administration since 1969.

Dr. Stinson has been a member of, among others, the Boudreau Committee on Nurse Practitioners and CNA's special committee on nursing research.

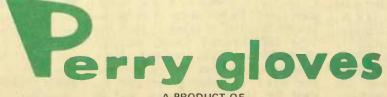
Jean Leask, recently retired director of the Victorian Order of Nurses, has been named Officer of the Order of Canada, one of Canada's highest honors.

(Continued on page 26)

Who makes surgeons' gloves for the giants of skill who are small in stature and wear size 5 1/2



Perry!...Naturally! But why? —Because small in stature doesn't mean small in the appreciation of proper fit and other features and benefits that have made Perry the most widely used latex surgeons' gloves—in any size! Like all Perry Latex Surgeons' Gloves, size 5½s have beaded wrists for added protection and strength, whisper thin palms to lessen hand fatigue, exclusive Dermashield® process that provides a durable hypo-allergenic finish and packaging to fit your preferred dispensing technique. If you'd like a sample of Perry Latex Surgeons' Gloves, please write us. By the way, you don't have to wear size 5½, we'll send you the size gloves that fit you.



AFFILIATED MEDICAL PRODUCTS LIMITED
90 Commercial Ave., Ajax, Ontario

#### names

(Continued from page 24)

Sister Mary Elaine (R.N., St Mary's Hospital School of Nursing, Montreal, Quebec; B.Sc.N., Ottawa University; M.Sc.N., Catholic University of America, Washington, D.C.; Sigma Theta Tau National Honorary Society of Nursing) has recently been appointed director of nursing at St. Mary's of the Lake Hospital, Kingston, Ontario.



Sister Mary Elaine has held a number of varied positions at St. Mary's Hospital in Montreal, including 15 years as director of nursing. She was a member of many committees of the

Association of Nurses' of the Province of Quebec and an active member of the Association of Hospital Administrators. She has been a member of the Task Force Committee on Nursing Education in Kingston and has been appointed to the Advisory Committee of St. Lawrence College Nursing Division.

Rose Imai has recently assumed the position of nursing consultant, health manpower services, Health and Welfare Canada.



A former research officer with the Canadian Nurses' Association, Ms. Imai had been on a special assignment in Washington, D.C., for the Pan American Health Organization prior to

joining the public service early in 1973.

M. Elizabeth Carnegie has been appointed acting editor of Nursing Research, having previously been senior editor of Nursing Outlook.

Dr. Carnegie earned her R.N. at Lincoln School for Nurses, New York City; A.B. at West Virginia State College, Institute W.Va.; M.A. at Syracuse University, Syracuse, N.Y.; D.P.A., New York University; and, in addition, studied at the University of Toronto.

Prior to beginning her editorial career in 1953 as assistant editor of the *American Journal of Nursing*, Dr. Carnegie had been dean and professor at the school of nursing, Florida Agricultural and Mechanical College, Tallahassee, U.S.A.

Esther Janzow is now district director of the Victoria Branch of the Victorian Order of Nurses, replacing Lillian Randall, who is on leave of absence.

Ms. Janzow (Reg.N., Royal Columbian Hospital, New Westminster; dipl. teaching and supervision, and B.Sc.N., University of British Columbia; M.A., University of Washington, Seattle), after serving in World War II with the Royal Canadian Army Medical Corps, became director of nursing, Jubilee Hospital, Vernon, B.C.

On joining the Victorian Order of Nurses, Victoria Branch, in 1957, Ms. Janzow had been assistant director of nursing at the Royal Columbian Hospital in New Westminster for several years. Then, she served for five years as rehabilitation nursing consultant in the Toronto office of the VON.

During the past year, Ms. Janzow taught psychiatric nursing at the Vancouver General Hospital School of Nursing.

Margaret R. Charters, director of nursing, Hamilton General Hospital, was elected president of the Council of the College of Nurses of Ontario at its meeting in June.

Una L. Ridley, Director of the School of Nursing, Kingston General Hospital, and Chairman, Health Services Department, St. Lawrence College of Applied Arts and Technology, was elected vice-president.

**Dr. H. Mahler** assumed his duties as the new director-general of the World Health Organization upon the retirement in July of **Dr. M.G. Candau**, its director-general for the past 20 years.

Dr. Mahler, originally from Denmark, has been with WHO since 1951. He is the author of several publications relating to the epidemiology and control of tuberculosis, and the application of systems analysis to health care problems.

Ola Dancause, recently retired, has been a public health nurse almost from the beginning of public health nursing in Ontario. A graduate of the Ottawa Civic Hospital School of Nursing, she studied public health nursing at the University of Western Ontario to prepare herself for her career in the southeastern counties of Ontario. Hers has been the personal touch, and the innovative approach, even to having a blacksmith construct an iron rim with four legs to hold the tobacco cans she used for sterilizing needles, and to converting a cutter into an ambulance of sorts to get a patient with a brain tumor to hospital in midwinter.

With little opportunity for hobbies, Ms. Dancause has given her spare time as a member of the board of directors of the Canadian National Institute for the Blind in Cornwall, and is a member of the Federation des Femmes Canadiennes Françaises.



Eileen Greenwood
has joined a 13member hospital
team in Surakarta
(Solo), Central
Java, to serve under
the auspices of
CARE-MEDICO. She
is teaching Indonesian nurses, as well

as ministering to patients.

Ms. Greenwood (Reg.N., St. Michael's Hospital School of Nursing, Toronto; B.Sc.N., U. of Western Ontario, London) has had two tours of duty working with leprosy patients: at the Kaonda Hospital in Zambia, Africa, and at the Christian Medical College Hospital in Velore, Tamil Nadu, India. During the past four years she has been on staff at the Stratford General Hospital, Stratford, Ontario.

Jo-Ann Tippett Fox, Assistant Professor, School of Nursing, Dalhousie University, has been awarded a Medical Research Council Studentship of \$4,050 per annum, renewable up to four years.

Ms. Fox graduated from the Montreal General Hospital School of Nursing, took her B.N. at the University of New Brunswick, and her M.Sc. (Physiology) at Queens University. She plans to return to Queens this September to gain her Ph.D. in gastrointestinal physiology.



Ferne Trout, Vancouver, recently joined the Canadian Council on Hospital Accreditation as nurse consultant. She will be involved in the research and demonstration program on hospital

use and clinical appraisal, funded by the W.K. Kellogg Foundation.

Ms. Trout (R.N., Vancouver General Hospital School of Nursing; B.A. and B.A.Sc., University of British Columbia; Dip.H.A., University of Toronto) has worked in British Columbia in nursing service, administration, and education, chiefly in hospitals. Her most recent appointment was as head of the two-year nursing program at Vancouver City College, Langara Campus.

## Canadian Nurse

50 The Driveway, Ottawa, K2P 1E2, Ont.



## Information for Authors

#### **Manuscripts**

The Canadian Nurse and L'infirmière canadienne welcome original manuscripts that pertain to nursing, nurses, or related subjects.

All solicited and unsolicited manuscripts are reviewed by the editorial staff before being accepted for publication. Criteria for selection include : originality; value of information to readers; and presentation. A manuscript accepted for publication in The Canadian Nurse is not necessarily accepted for publication in L'infirmière Canadienne.

The editors reserve the right to edit a manuscript that has been accepted for publication. Edited copy will be submitted to the author for approval prior to publication.

#### Procedure for Submission of Articles

Manuscript should be typed and double spaced on one side of the page only, leaving wide margins. Submit original copy of manuscript.

#### Style and Format

Manuscript length should be from 1,000 to 2,500 words. Insert short, descriptive titles to indicate divisions in the article. When drugs are mentioned, include generic and trade names. A biographical sketch of the author should accompany the article. Webster's 3rd International Dictionary and Webster's 7th College Dictionary are used as spelling references.

#### References, Footnotes, and **Bibliography**

References, footnotes, and bibliography should be limited OCTOBER 1973

to a reasonable number as determined by the content of the article. References to published sources should be numbered consecutively in the manuscript and listed at the end of the article. Information that cannot be presented in formal reference style should be worked into the text or referred to as a footnote.

Bibliography listings should be unnumbered and placed in alphabetical order. Space sometimes prohibits publishing bibliography, especially a long one. In this event, a note is added at the end of the article stating the bibliography is available on request to the editor.

For book references, list the author's full name, book title and edition, place of publication, publisher, year of publication, and pages consulted. For magazine references, list the author's full name, title of the article, title of magazine, volume, month, year, and pages consulted.

#### Photographs, Illustrations, Tables, and Charts

Photographs add interest to an article. Black and white glossy prints are welcome. The size of the photographs is unimportant, provided the details are clear. Each photo should be accompagnied by a full description, including identification of persons. The consent of persons photographed must be secured. Your own organization's form may be used or CNA forms are available on request.

Line drawings can be submitted in rough. If suitable, they will be redrawn by the journal's artist.

Tables and charts should be referred to in the text, but should be self-explanatory. Figures on charts and tables should be typed within pencil-ruled columns.

The Canadian Nurse

OFFICIAL JOURNAL OF THE CANADIAN NURSES' ASSOCIATION

THE CANADIAN NURSE 27

# Pampers Pampers oives ou both abreak

## Keeps him drier

Instead of holding moisture, Pampers hydrophobic top sheet allows it to pass through and get "trapped" in the absorbent wadding underneath. The inner sheet stays drier, and baby's bottom stays drier than it would in cloth diapers.



## Saves you time

Pampers construction helps prevent moisture from soaking through and soiling linens. As a result of this superior containment, shirts, sheets, blankets and bed pads don't have to be changed as often as they would with conventional cloth diapers. And when less time is spent changing linens, those who take care of babies have more time to spend on other tasks.

PROCTER & GAMBLE

### **Canada Pension Plan Discriminates**

Two Canadians die. Each leaves a spouse and three young children.

Prior to death, both of the deceased had worked, each receiving an annual income of over \$5,000. Each had contributed the same amount of money to the Canada Pension Plan since 1966.

The CPP provided the spouse of one of the deceased with \$560\* and, in addition, a monthly pension of \$71.12, plus \$28.15 per month for each of the three children — a total of \$155.57. The spouse of the other deceased received \$560. Period. No CPP monthly pension for this spouse and children.

Why this difference? The answer is simple, although perplexing: one person who died was male, the other, female.

In other words, when a male contributor to the CPP dies, his survivors receive the lump sum death benefit (\$560), the widow's pension, and the orphans' benefit. But when a female contributor to the Plan dies, her husband receives only the death benefit. He gets no pension unless he is disabled at the time of his wife's death (which he must prove), and was being maintained wholly or substantially by her before her death; nor do the children receive benefits unless they, too, were being maintained "wholly or substantially" by her.

Yet both male and female contributors to the Plan are treated alike as far as payments are concerned.

There must be some mistake, you say. Discrimination such as this doesn't occur in our Just Society. Unfortunately it does and, in this case, is brought about and maintained by the cobwebbed thinking and the medieval attitudes of our federal legislators.

\* Actually, the spouse receives less than \$560. The lump sum of \$560 is paid to the estate, becomes part of the deceased's income, and is thus subject to immediate taxation.

Pension plan outdated

The CPP, based on the erroneous assumption that men are the breadwinners of all Canadian families, is outdated. Had it been enacted in 1900, it might have made sense. Even more serious, however, is the fact that the federal government, in perpetuating this discriminatory Plan, is acting illegaly: It is defying the Canadian Bill of Rights, which guarantees equal treatment for both sexes. Someone should test the legality of this plan, which treats the female contributor so shoddily.

The discriminatory nature of the Plan was brought to the government's attention in 1970, when the Report of the Royal Commission on the Status of Women in Canada was released. The commissioners said, in part: "We cannot agree with this differential treatment. Even if the financial consequences are not the same, we see no reason why the husband of a contributor should not have the same protection as the wife of a contributor. Nor do we see any reason why the children should be wholly deprived of the financial support they have received from their mother."

Noting that the Quebec Pension Plan has similar discriminatory features, the Commission on the Status of Women recommended that legislation on the CPP and the Quebec Pension Plan be amended "... so that provisions applicable to the wife and children of a male contributor will also be applicable to the husband and children of a female contributor."

What, then, is the federal government doing to eliminate the sections of this Plan that discriminate against the working woman and her family? Nothing.

\*\* The support of "two-thirds of the provinces representing two-thirds of the Canadian people," must be obtained before the Canadian Pension Plan can be amended.

In its Working Paper on Social Security in Canada, introduced in April 1973 by the minister of Health and Welfare Canada, the federal government outlines "...the broad directions of policy which would, in the view of the Government, lead to a more effective and better coordinated system of social security for Canadians." Under the section dealing with the CPP, the government suggests various amendments that should be considered during a federal-provincial review.\*\*

These suggested amendments are divided into those for immediate consideration and those "that might best be considered during the course of the over-all review rather than immediately." Unfortunately, the proposal concerning equal treatment of men and women who are participating in the CPP is not in the "immediate" category.

#### Write to your MP

So, the Canada Pension Plan is being reviewed by the federal and provincial governments. And, unless pressure is brought to bear on both these levels of government, it is unlikely that the discriminatory sections will be amended. The federal government is not recommending that this amendment be made *immediately*, and it is improbable that the provincial governments will give it priority.

There is one way to get action. Write now to your member of parliament and to the Hon. Mare Lalonde, minister of Health and Welfare Canada. Get your husband to write a letter, too. Because if there ever was an issue that affected the whole family, this is it. Demand that the Canada Pension Plan, which we are abliged to belong to, is amended at once—not ten years from now.

— Virginia A. Lindabury

## Controlling the fight/flight patient

Community hospitals are faced with severely disturbed patients who display an out-of-control, fight/flight reaction to persons trying to help them. The author suggests ways to care for such a patient until he regains control of himself.

#### Jean A. Reid, B.N.

Screams and scuffling can be heard from Room 10. Her husband, a doctor, and a nurse are all struggling with an obese Italian lady. Fighting, screeching, and determined, she is making a beeline to a second-story window, dragging the three bodies with her. Here is the making of a ward crisis: an acutely overactive, aggressive patient out of control.

For some time I have been concerned with the paucity of written, as well as verbal, information from my colleagues on how to control a patient who is acutely ill and aggressively outof-control. There is some excellent material published on reasons for a person's inability to control himself and the feelings of those called upon

to assist in the crisis. Procedures involving restraints or physical holds for this type of patient are controversial. Perhaps that is why I was never formally taught these control measures. I have wondered how

Ms. Reid is a graduate of Edmonton General Hospital school of nursing; she had postgraduate training in psychiatric nursing at the provincial mental hospital in Ponoka, Alberta, and received a B.N. from McGill University. She has been nursing supervisor in the outpatient department and is presently nurse-in-charge of the brief therapy unit of the Allan Memorial Institute, a division of the Royal Victoria Hospital, Montreal.

the police cope with these people in the community. One hears of various forms of self-defence that "everyone" should know and be able to use.

Restraint and control measures used in the old mental hospital days are not acceptable in modern, open, community hospitals. Yet community hospitals are faced with patients who are severely disturbed and who display an out-ofcontrol fight/flight reaction to helping persons. It is imperative that we, as helpers, find humane ways of dealing with the crisis - ways that are acceptable to those being helped, as well as to those whose responsibility it is to help. My experience over the years with many able staff has prompted me to share a few of the how-to's.

An individual's personality dynamics may always be called forth to help us understand violent and aggressive behavior patterns, but we must face the fact that we do not often have the time to engage in such a searching relationship with the patient. I have found that the single, and the most simple, conceptual framework upon which to work, for both patient and staff, is that of understanding the anxiety underpinnings of the fight/flight behavior. My suggestions are based on teaching this concept to staff and building management approaches that help deal with anxiety in both patients and staff, while controlling its behavioral

manifestations: fight and flight. Management of out-of-control behavior is, therefore, concerned with protection for all concerned.

The primary concern is the patient. A secondary concern is those asserting controls, staff, family, or other patients. And a third concern is others in the area, such as patients too ill to protect themselves and those too fearful to help or control themselves, be they patients or staff.

#### Preparation of staff

Imbue staff with a sound understanding of the anxiety underlying fight/flight behavior.

For predictive and preventive purposes, identify patients who may resort to out-of-control behavior. PRN medication may be prescribed on admission so the nurse can head off a crisis before anxiety builds too high. This is important for the patient, as well as the atmosphere on the ward. During fight/flight crisis:

- l. Mobilize help in terms of numbers, that is, call additional medical or nursing resources. There should be at least three staff members and no more than six. Never try physically to control a frightened patient by yourself. Both of you end up getting hurt broken bones, scratches, and bruises are common, or dancing around like a couple of amateur wrestlers.
- 2. Organize the crisis team with a leader, not necessarily a doctor or nurse, but the person who knows the patient. A leader is important for the staff, who have been quickly assembled, as it is she who makes and states the plans. For the patient, this leader is especially important as he feels someone is in charge who is able to help in this chaotic situation.
- 3. Prepare PRN medication.
- Remove spectacles, watch, jewelry.
   They may get damaged or, more seriously, injure the patient or staff if there is a scuffle.
- 5. The actions of each team member relative to the patient are assigned by the leader. The decisions made by the leader must be followed, even if those helping feel that the plans could be improved upon. Leave the discussion until later and get on with the task at hand. Patients are extremely sensitive to any feelings of disagreement or ambivalence between staff, and tend to act out. The plans will include: where staff is taking the patient, whether the pa-

tient is to be given medication before or after the move, whether it is necessary to remove the patient's clothes, what staff member will be responsible for what act of control, and the management of other patients.

#### Management of other patients

One staff member should explain to other patients on the unit what is happening and why it is necessary to control a patient physically. Patients should plan how they can help — by getting off the ward for a time to occupational therapy, visiting another ward, or going for a walk outside with a staff member. The nursing staff member's judgment of the height of anxiety within the ward setting and her ability to catch the patients' mood may demand that she help them deal with the ever-present but unspoken thought "it could happen to me!" PRN medications may be required to tide some extremely anxious patients over the immediate disruption.

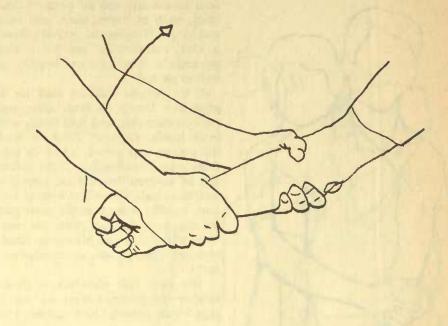


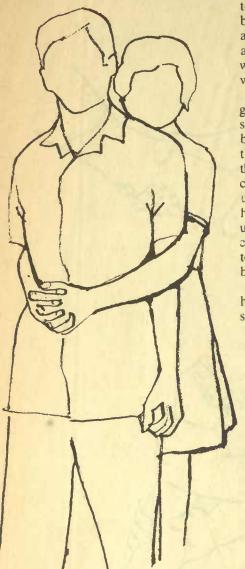


Figure 1: The right way (top) and the wrong way, (bottom) to hold the arm of an individual who is out-of-control. In the right way, the staff member puts one hand over the elbow joint and one over the wrist, placing her hands so her arms flex in the same direction as the patient's.

A patient may be asked to change rooms to provide a single or quiet room for the one who is undergoing the crisis. Isolation need last only for 24 to 48 hours, until the medication has helped the patient to get control of himself.

#### Management of the patient

At a signal from the leader, the crisis team all move in very close around the disturbed patient. Always approach a patient from the side or rear, never from the front, as that sets up a posi-



tion for a fight. The closer all staff get to the patient, the less danger that the patient can use a limb for striking out, lessening the space available for such leverage. The physical closeness of the staff and patient can be likened to a child in a temper tantrum, where the mother sometimes lifts the child up and holds him tightly until he is able to control himself. This closeness protects the patient from doing something about which he would be embarrassed later.

Male patients tend to use their fists or articles for weapons. Female patients tend to use any and all parts of their body, such as limbs, teeth, and head and to spit. Remove the patient's shoes; a kick well-directed can be a long workmen's compensation haggle, as well as painful.

If the patient makes a dash for it, grab him firmly on both arms, one staff on each side, and hold firmly with both hands. (Figures 1,2,3,4.) Back the patient into a wall, a bed, or anything solid, even the floor if the patient can be lowered there. If the patient is unable to walk where you wish to take him, another team member must pick up the patient's legs from the side, close to the hips, and hold them firmly together close to the team-member's body.

The two staff members who are holding the patient's arms will try to support the patient's back and head for carrying. Another staff member is useful for controlling the patient's head, particularly if the patient is a female. This fourth staff member places one hand under the patient's chin and one hand at the back of the patient's head; this prevents bites or the head being used as a battering ram, injuring the patient himself and/or staff. (Figure 5.)

A patient who is off balance, and not standing on his two feet, has lost his physical control of the situation. People are prone to use the phrase "stand up and fight!" Therefore, a patient who is lying down is in a weak position and much easier for the staff to manage.

Once the patient is lying down, the staff can make better use of their weight to pin the patient and control his struggling. It is imperative for safety that staff continue to hold the patient firmly while medications are administered and, even after administration, until the medication is effectual.

If the patient has been successfully controlled on the floor, leave the patient and staff there while medicating him and until he becomes more relaxed.

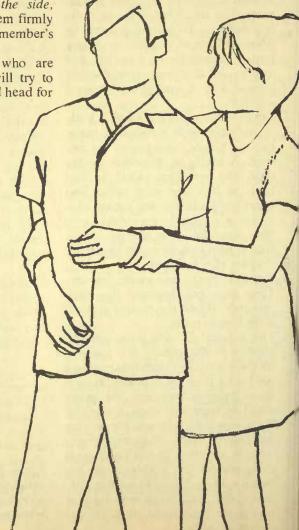


Figure 2: One nurse can hold a patient, although there is a danger that the patient may throw her over his head. The nurse's arms are over the patient's elbow joints, and her hands clasped in front of him. Standing close to him, she can push him along gently.

Figure 3: This is a better position than in Figure 2. The nurse is behind and to one side of the patient. Standing close to him, she puts her far hand over the elbow joint and her near hand over his wrist. She can use her knee behind the patient's knee as a lever to direct him where she wants him to go.

Make no move to undress the patient — other than to expose an arm or a buttock for injections — and make sure he is informed of intended actions. Fear of sexual attack is strong in a defenceless person, and removal of clothing arouses sexual anxiety in both male and female.

An adult's acceptance of helplessness is different from that of a child. The process of being held forcibly by other persons means many things to individuals; the need to fight against this external threat is great. It is, therefore, important that the staff carry out controlling measures as firmly and gently as possible, without feelings of anxiety and aggression within themselves. Staff who have been hit at and wish to hit back will exacerbate the patient's aggressiveness. In my experience, male staff are more prone to a retaliatory feeling response than female staff.

Patient isolation is needed to cut down stimulation to all his senses; but never leave the patient alone. Two or more members of staff should stay near him until he is less fearful and in control of himself. Staff members support each other; they must be rotated every two or three hours for a rest, and given a chance to verbalize their fears or problems with the crisis.

When the patient is able to walk or be transported to a single or quiet room, caution and awareness of his restlessness or unpredictability are primary concerns. He can be nursed on a mattress on the floor to protect him from falling out of bed. A sheet, folded lengthwise and draped over a lying patient with staff either holding the sides down or sitting on them, removes the threat of body contact between patient and staff.

No matter what language the patient speaks or understands, talk to him in calm tones, explaining what is happening. For instance, the nurse might say: "You are showing us that you are frightened"; "You are not in control of yourself"; "We will not let you hurt yourself or harm others"; or "We are going to help you."

Use short sentences and repeat instructions with reassurance: such as, "Come with us. Walk. Stop kicking. No, do not bite. We will hold you firmly. Try to cooperate. That's better."

The staff members' tone of voice conveys that they are in control, even if the patient is not. Short sentences, stated firmly, cut through the fear. Our 36-year-old Italian lady, who spoke little English at the best of times and none at all during her worst, said, "I thought my husband he left me in whore house — that why I fight to get away."

As soon as possible, help the patient begin to feel that he can control himself. One way to do this is to offer choices in fluids. The patient is usually quite dehydrated, due to his heightened anxiety, and will need fluids. Offer him the fluid of his choice, 2 to 4 oz., in a plastic glass or paper cup (he may throw it at the staff). This simple act,

presented as comfort, is the beginning of an understanding and trusting feeling between patient and staff. It is important that the offerings are carried out with a sense of comforting and caring, when a patient is at his worst.

The medication will relax the patient emotionally and physically. He may need to void. Two staff members should accompany him to the toilet. Urinals and bed pans are uncomfortable and effective weapons. Be aware that the patient may try to escape. He must be

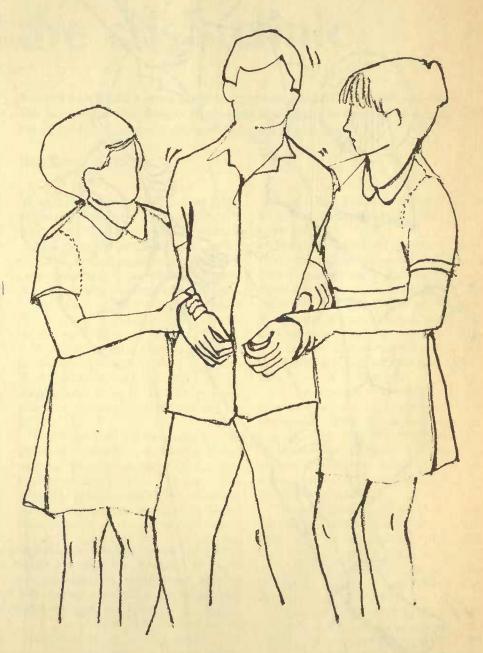
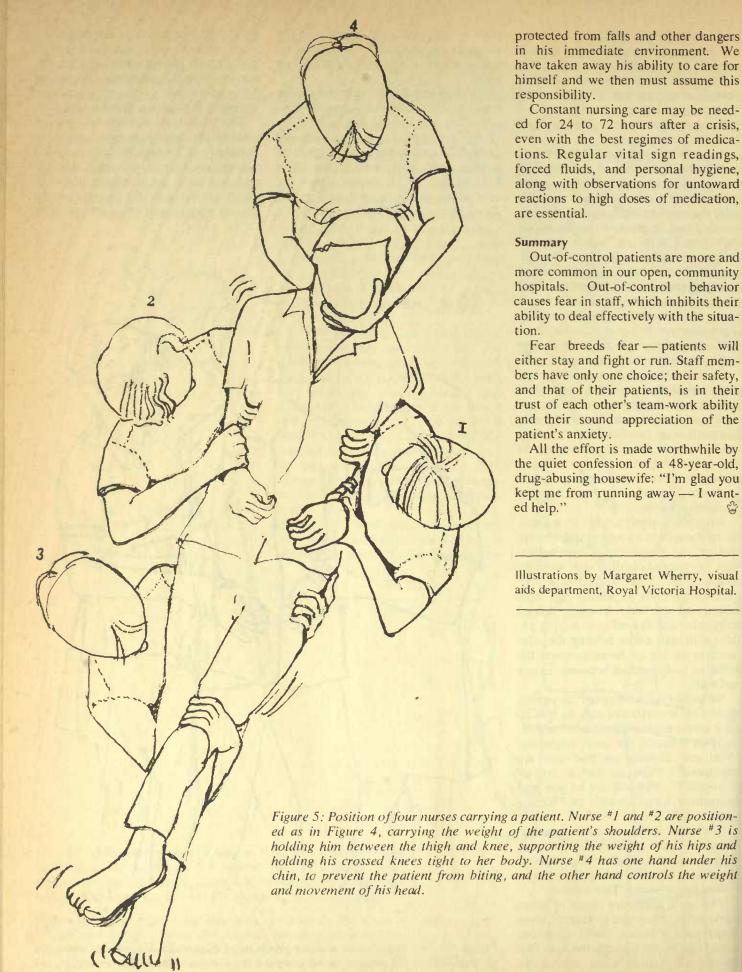


Figure 4: Two nurses can use the position of Figure 3. The nurses' arms are crossed behind the patient, hands clasping the patient's elbows and wrists. Again, the nurse can use her knee to guide the patient's direction.



## Help in a hurry: the crisis clinic

A nurse who staffs a crisis clinic in a general hospital discusses her work. The purpose of the clinic is to provide individuals in stressful situations with the opportunity to see a professional person quickly.

Sister Mary Mona, B.N.

On an ordinary Monday morning in the outpatient emergency department, I suddenly became aware that a condition of hyperactivity prevailed. The influx included cardiac patients, accident victims, candidates for emergency surgery, and others with less urgent conditions. In the midst of the activity sat or paced five psychiatric patients: three repeaters and two frightened new callers.

Was such a picture unusual? Not at all. In fact, it was the repetition of such situations that made us ask how we could render more rapid, efficient, and effective service to individuals seeking help.

Due to present health systems, more and more patients are coming to the hospital for help; among them are persons in emotional crisis. The number of available psychiatrists to see, evaluate, refer to appropriate services, or follow such persons in treatment is limited; nor do all who come in a crisis situation require the services of a psychiatrist.

A crisis per se is not an illness, but a person may be suffering from chronic or acute mental illness or pathological behavior patterns when he goes into a

Sister Mary Mona is a graduate of St. Mary's Hospital School of Nursing, Montreal, and earned her B.N. from McGill University, Montreal. She is presently charge nurse in the crisis clinic at St. Mary's Hospital, Montreal, Quebec.

state of crisis. These conditions have to be evaluated separately and treated appropriately.

Since a crisis is time limited, generally no more than six weeks duration, a little help, rationally directed and purposefully focused at a strategic time, is more effective than extensive help given at a period of less emotional accessibility. But who will give this help? Who will be available at unpredictable and unscheduled times? And where should such service be offered?

In asking such questions we began to assess the reasons crisis centers are becoming a necessary adjunct to existing agencies and institutions that are obviously not meeting the needs of present-day society. In seeking an answer, a crisis clinic was opened at St. Mary's Hospital.

The department of psychiatry and the crisis clinic are adjacent, on the same floor of the hospital. The clinic has a large waiting room, closed off from the main corridor, and an office in which to interview a patient. The decor is quiet and restful.

Clinic services are free to Ouebec residents of three or more months. The center is open from 0830 hours to 1530 hours Monday to Friday. We serve the

The author's bibliography is available on request to the Librarian, CNA House, 50 The Driveway, Ottawa, Ontario K2P 1E2.

English- and French-speaking population in our sector and, at times, other ethnic groups, depending on the linguistic talents of our personnel.

The clinic staff consists of one registered nurse full-time and three rotating psychiatrists part-time, one of whom is the coordinator of the crisis clinic services; a psychologist, a social worker, and an occupational therapist are available to the clinic. We do not, as yet, use volunteers. The nurse is responsible for operating the clinic; the part-time personnel are called upon as the need arises. A short daily meeting is held at which the psychiatrist on call, the nurse, and the social worker discuss care of current patients.

Patients coming to the crisis clinic are followed there for a maximum period of one week and, if indicated, are then channeled to more continuous treatment facilities. These include: admission to the psychiatric ward, individual outpatient psychiatric follow-up, family therapy, behavior therapy, and evening group therapy. Or a patient may be referred to another hospital or agency in which more expedient or specific treatment can be offered.

Any psychiatric emergency that is being followed in our psychiatric outpatient department or day center, for example, may also be referred to the crisis clinic for brief intervention. However, the clinic does not replace these services. It is only a short-stay, crisis-oriented, back-up service for the emergency department, the area that would care for these emergency patients were the crisis clinic not in existence.

#### Clinic objectives

The original, broad purpose of our crisis clinic was to help decongest the emergency department by transferring suitable psychiatric patients to the crisis clinic for further work-up and refer-



The author, Sister Mary Mona, counsels a patient in the crisis clinic.

ral. After three and one-half months of operation, the clinic was serving other areas as well, and fulfilling a variety of purposes.

The main and general objective is to provide individuals in stressful situations with the opportunity to see some professional person quickly, to prevent further psychological decompensation, and thus contribute to better mental health in the community.

A person in crisis who comes to our hospital must register in the emergency department. We require all patients to have a physical examination there before the psychiatrist is called for consultation.

An illustration emphasizes the importance of this: A female patient with a past diagnosis of manic-depressive psychosis came to the emergency department. A marriage crisis had recently arisen and the patient was exhibiting manic symptoms. Admission to the ward was indicated, but no bed was available so the crisis had to be dealt with immediately. However, the patient also complained of chest pain, which could have been a manifestation of her anxiety. The doctor in the emergency room did an electrocardiogram on the patient; the result showed a recent myocardial infarct. The woman was admitted to a medical ward with concurrent follow-up by the department of psychiatry, and she was eventually transferred to the psychiatric unit.

If a medical "all clear" is given, or if a medical problem can be dealt with at a later date, the patient in the emergency department is seen by the psychiatrist on call. On evenings, nights, and weekends, an intern may see the patient first and then consult with a psychiatrist, but it is a rule of the department of psychiatry that all suicidal patients must be seen by a qualified psychiatrist.

The medical examination is required only on the first visit or if two or three months have elapsed since the last medical examination was done. It may be dispensed with when it is contraindicated. For example: A young male patient came to the emergency department in a state of extreme agitation. He could not control himself sufficiently to give the necessary information to the secretary and he felt a great urge to hit someone physically. However, with a quiet approach our psychiatric supervisor was able to encourage him to come to the crisis clinic. After ventilating his fears and anxieties at length, he was able to register in emergency, where a physical examination was done without undue stress to him.

Not all patients are candidates for the crisis clinic. Individuals who are severely suicidal, agitated schizophrenics, those who are manic or suffer from

organic confusion or complications of alcoholism, and aggressive psychopaths are not considered appropriate candidates.

Telephone calls form a large percentage of our contacts. These psychiatric emergency calls are filtered through the crisis clinic; the nurse screens and advises the patient for more expedient treatment. Many patients who phone, later come to the crisis clinic.

These are some areas in which the nurse was given a more independent, yet collaborative, role in setting up and operating the crisis clinic.

The location assigned for the crisis clinic underwent a face-lifting so the clinic operated from the emergency department in the beginning. This proved to be a blessing in disguise for the nurse; she was given the opportunity to accompany the staff psychiatrist while each patient was interviewed, and she often participated in the interviewing process. A six-month experience in interviewing techniques was an unexpected and valuable preparation for crisis intervention work.

#### Nursing responsibilities

When the area for the crisis clinic was ready, the role of the nurse became more defined. Her preliminary responsibility was outlined by the chief psychiatrist, who stated that the clinic would not accept patients unless screened and approved by a psychiatrist or the crisis clinic nurse.

Apart from referrals from the emergency department, there are those coming from private psychiatrists in our outpatient department, requesting intervention for specific patients between scheduled appointments or while awaiting an initial appointment. Other referrals come from medical wards where there is a patient requiring some form of psychological support. Such a

patient may come to the clinic or the clinic nurse may visit him.

Another group of patients seen by the crisis clinic nurse are those awaiting admission to our psychiatric ward. In this case, the patient is maintained during the crisis, and often adjustment to the ward is made easier by previous contact with the clinic personnel.

Of course, there are always a number of patients who require crisis intervention only and do not need referral to a psychiatrist for further treatment. The nurse may be the first-line contact with the patient in emergency, for instance, if the intern is not available. She then consults with the psychiatrist on duty. The crisis clinic nurse reaches out to the community by telephoning patients who do not keep their first appointment with the psychiatrist or the clinic. Sometimes a little encouragement helps the patient to accept the care he needs.

In all these functions, the nurse helps to reduce repeat visits to the emergency department and to decrease the number of admissions to the ward. She may also spot medical problems and report them to the doctor.

There have been a few instances that do not fall into the category of a crisis situation. For example, a patient phoned in complaining of a very sore throat. Since this might have resulted from the medication, the psychiatrist wanted some blood work done and a throat swab taken. The doctor would not be at the hospital the next day so he asked to have the patient come to the crisis clinic for a word of reassurance, and arrangements were made with the laboratory to carry out the necessary procedures. The patient was spared possible tedious waiting in the emergency room or elsewhere. In all these functions, there does not seem to be duplication of roles. Rather, the crisis clinic serves

as a link between the emergency room, the outpatient psychiatric department, the ward, and the community.

The functions of our crisis clinic are primarily handled by the nurse. Her role allows for considerable initiative, independence, and responsibility. Such a role in no way replaces the doctor, but rather collaborates with him. Those doctors who accept the nurse in such a role help make it possible for her to develop her potential and to look toward yet unexplored horizons. Working in such a crisis clinic is an exciting challenge.

## Hypoglycemia

Some facts about a misunderstood condition.

Bernard M. Wolfe, FRCP(C), and Rosemary Powers, M.S.

Concern has been expressed in the press recently about the widespread and unrecognized occurrence of hypoglycemia. Hypoglycemia is defined as a level of blood sugar that is below normal limits. Current lower limits for blood glucose, the principal blood sugar, vary from 40 to 50 mg/100 ml, <sup>2,3</sup> the corresponding range for plasma being 46 to 58 mg/100 ml.<sup>4</sup>

Hypoglycemia is neither a symptom nor a disease; it is a sign of disease when it occurs inappropriately.

#### Recognition

The presence of hypoglycemia is suggested by signs and symptoms such as hunger, sweating, tremulousness, mental confusion, or unconsciousness. Symptoms characteristic of hypoglycemia are frequently encountered in patients who have unstable diabetes mellitus, especially after an excessive dose of insulin, failure to eat regularly, or indulgence in excessive physical activity.

Since symptoms similar to those arising from intense activation of the autonomic nervous system by hypoglycemia can also occur in other disorders, such as an anxiety state, hypoglycemia must be confirmed by accurate determination of the glucose content of blood or plasma. Blood glucose values that are falsely low due to glycolysis by red blood cells<sup>5</sup> can be avoided by immediately mixing the blood sample with a preservative such as sodium fluoride.<sup>6</sup>

Deproteinization of the blood (or plasma) in the laboratory prior to deter-

mination of glucose reduces interference by hemolysis, bilirubin, and uric acid, <sup>7,8</sup> which also may artificially lower the value obtained for the glucose concentration.

#### Classification of hypoglycemia

Numerous schemes have been devised to classify the different kinds of hypoglycemia. A classification of hypoglycemia according to physiological mechanism is shown in *Table 1*.

The most frequently encountered forms of hypoglycemia relate to excess insulin and are listed in Group I. Excess insulin often results from administration of a dose that is too high.

Hypoglycemia due to exogenous insulin typically occurs at a time coinciding with the peak activity of the particular type of insulin administered. Thus, following administration of regular insulin in the morning, the lowest blood glucose values tend to occur later in the morning; following morning administration of a medium-acting insulin, such as NPH or lente insulin, the lowest glucose values tend to occur in the late afternoon.

#### Patient History #1

A 16-year old woman in her fourth month of pregnancy was admitted to hospital for assessment of diabetic

Dr. Wolfe is Chief of Endocrinology, University Hospital, London, Ontario, and Associate Professor, Dept. of Medicine, the University of Western Ontario. Rosemary Powers is Clinical Nurse Specialist, University Hospital, London, Ontario. control. She had been discovered to be a diabetic at the age of 10. Her diabetes had always been unstable; however, she had never been in coma.

Prior to admission, she had been receiving 80 units of protamine zinc insulin and 40 units of regular insulin in the morning. She complained of sweating episodes, particularly at night, during the week prior to admission.

On the evening of her first day in hospital her supper arrived about an hour later than she usually ate at home. During this interval she began to perspire and to feel faint. Determination of the plasma glucose revealed a value of 30 mg/100 ml. Administration of a glass of orange juice immediately relieved the symptoms.

All protamine zinc insulin was subsequently discontinued, and the patient was placed on two doses of NPH insulin (before breakfast and before supper), resulting in complete disappearance of hypoglycemic symptoms and satisfactory control of glucose levels.

#### Patients respond differently

There is marked variation among individuals as to the time when the lowest blood glucose values are attained after subcutaneous administration of any given type of insulin. Sulphonylureas of the long-acting type (for example, chlorpropamide), which act by releasing insulin from the pancreas, may also cause profound and irreversible hypoglycemia, especially in patients over 70 years of age and in those with renal failure. In some patients, endogenous release of insulin is inap-

OCTOBER 1973

propriate in quantity and/or timing to body requirements.

In patients who have undergone gastrointestinal surgery (gastrectomy or pyloroplasty), hypoglycemia may occur either early (within an hour after ingestion of glucose or other carbohydrate) or late (two to three hours after). A five-hour glucose tolerance test is useful in making the diagnosis. Similarly, patients with functional hypoglycemia and those with the reactive hypoglycemia of diabetes mellitus may have a delayed insulin response to ingestion of glucose, resulting in hypoglycemic values two to four hours later.

Fasting hypoglycemia not attributable to insulin, sulphonylureas, phenformin, or other drugs known to cause hypoglycemia, may be due to an insulinoma or a nonpancreatic tumor producing hypoglycemia.

Demonstration of an insulinoma depends on evidence of inappropriately high levels of serum insulin for the simultaneous level of blood glucose. Techniques designed to provoke hypoglycemia may be indicated in patients whose history is strongly suggestive of insulinoma. These techniques include intravenous administration of tolbutamide and/or the performance of a 72-hour fast, with repeated sampling of blood glucose and serum-insulin levels at intervals appropriate for each test.

Patient History #2

A 67-year-old woman was admitted to hospital with a complaint of a tremor of her right arm. Physical examination showed a partial loss of vision in the right eye (hemianopsia). Neurological investigation and surgical exploration revealed the presence of a cerebral tumor in the left parietal area (benign hemangiopericytoma).

The patient recovered and managed satisfactorily until she was readmitted to hospital seven years later in a confused and disoriented state. She was then found to have a fasting blood sugar of 40 mg/100 ml blood. Investigations showed a recurrence of hemangiopericytoma, with evidence of metastases to the left lung, liver, and spine.

Glucose tolerance curve showed a low-fasting blood glucose of 29 mg/100 ml., 1-hour value of 204, 2-hour value of 270, and 3-hour value of 312. Simultaneous serum insulin values were: fasting, 6 microunits/ml; 1-hour, 15; 2-hours, 24; and 3-hours, 33.

Intravenous tolbutamide test revealed a fasting blood sugar of 70 mg/100 ml, 15-minute value of 58, 40-minute value

#### TABLE 1

#### Causes of Hypoglycemia

Group I

Impaired secretion of glucose into the blood, combined with excessive removal.

1. Pharmacologic (insulin and/or sulphonylureas).

- 2. Inappropriate (delayed and/or excessive) release of insulin after food (functional hypoglycemia, dumping syndrome, reactive hypoglycemia of diabetes mellitus, leucine sensitivity).
- 3. Insulinoma.
- 4. Alcohol (ethanol).

Group I

Impaired secretion of glucose into blood.

- 1. Severe hepatic insufficiency (liver necrosis due to toxins, inflammation, neoplasm).
- 2. Deficiency of substrate for gluconeogenesis (prolonged starvation, severe malabsorption, ketotic hypoglycemia).
- 3. Deficiency of hormones stimulating gluconeogenesis (glucocorticoid, thyroid, and/or growth hormone).
- 4. Inhibition of gluconeogenesis (hereditary fructose intolerance)

5. Inhibition of glycogenolysis (galactosemia).

6. Deficient or abnormal glycogenolysis (Glycogenosis types I, III, VI, and IX).

Group III

Unclassified.

1. Nonpancreatic tumors.

2. Twin pregnancy.

3. Severe muscular exercise.

of 46, and 60-minute value of 43. Simultaneous serum insulin values were as follows: fasting, 10 microunits/ml; 15 minutes, 23; 40 minutes, 15; and 60 minutes, 17.

Levels of serum insulin were low to normal for the simultaneous value of blood glucose, thus excluding an insulinoma. Neither diazoxide (to diminish endogenous insulin secretion) nor chemotherapy to slow the tumor were of much value in prolonging this patient's life.

Other causes of hypoglycemia

Like insulin, 10 ethyl alcohol (or ethanol) has recently been found to affect both the removal of glucose from blood,\* as well as the rate of secretion of glucose into blood. Some individuals are particularly prone to develop hypoglycemia during ingestion of ethanol; however, after a sufficient fast (three days or more), almost everyone appears to develop hypoglycemia with ingestion of even small amounts of alcohol.

Hypoglycemia due to disorders listed in Group II tends to occur during fasting. Generalized liver failure is an important cause of hypoglycemia. Some of the more common causes of severe liver failure are listed in the table. Since the synthesis of glucose (in liver and kidney) depends on the availability of amino acid and glycerol derived from peripheral tissues, such as muscle and adipose tissue respectively, exhaustion of these tissue stores in starvation and other states ultimately leads to a deficiency of carbon skeletons for formation of glucose, and consequently results in hypoglycemia.

Hypoglycemia has long been recognized to be a manifestation of endocrine disorders, including panhypopituitarism, Addison's disease, and growth hormone deficiency. These forms of hypoglycemia are attributable to deficiency of glucocorticoid, thyroid, or growth hormone that stimulate the rate-limiting enzymes of gluconeogenesis in liver. There has been steady progress in unraveling the complexities of hypoglycemia associated with disorders of the regulation of the enzymes of glucose synthesis and glycogen breakdown. Group III includes several hypoglycemic disorders that are incompletely understood.

#### Role of Nurse

Nurses can play a major role in assisting the patient to recognize and to understand his hypoglycemic symptoms. 11,12,13 The nurse should be present when the physician explains the cause and treatment of the patient's symp-

<sup>\*</sup> B.M. Wolfe and R.J. Havel, Unpublished observations.

toms to him so she can later reinforce these explanations and clarify points that may subsequently arise.

Often it is necessary to repeat to the patient several times the explanation of why it is essential for him to follow strictly the proposed dietary or drug

therapy.

Some patients have difficulty understanding why regular eating patterns are so important in the prevention of hypoglycemic symptoms. Concerning medications, nurses may play an active part not only in administering medications and explaining why they are important, but also in educating the patient to take the correct amount of the medication at the prescribed times. This is especially important in patients who have unstable diabetes.

Since the patient's only way of monitoring the blood glucose is to test his urine (Clinitest appears to be most reliable), he must learn how to do this competently. It is of great value for him to appreciate that hypoglycemia does not occur when the urine is positive for glucose (provided the bladder had been emptied shortly before the "second-voided" specimen of urine was obtained for testing).

Nurses may also assist the patient in gaining confidence by teaching him how to avoid hypoglycemia and how to counteract hypoglycemia should it occur. For instance, the patient should be taught to carry some form of sugar with him at all times, and should be encouraged to obtain glucagon and a syringe for glucagon administration in case of severe hypoglycemia that could lead to unconsciousness.

Nurses can assist the patient by teaching the family how to recognize hypoglycemic symptoms and how to treat them, whether it be by administration of sugar by mouth or by intramuscular injection of glucagon if hypoglycemia leads to unconsciousness.

A patient who is prone to hypoglycemia, for example, a diabetic, should be encouraged to obtain a Medic-Alert bracelet or necklace that will assist others to recognize he has a condition that may result in hypoglycemia.

The patient should also be taught to record faithfully the results of urine testing. This will enable his physician to assist him in obtaining the best possible regulation of blood sugar.

#### Diet

The nature of the dietary treatment for hypoglycemia depends on its underlying cause. Diabetic patients who are

taking insulin and who may be prone to insulin-induced hypoglycemia should receive regular meals that are constant in quantity and composition. Patients who have functional hypoglycemia, reactive hypoglycemia, or dumping syndrome require frequent, small meals. This may be achieved by giving them three meals a day plus mid-morning, mid-afternoon, and evening snacks.

Sometimes it is helpful to reduce the carbohydrate content of the diet of the latter group of patients and to replace this carbohydrate with protein and/or fat. Patients who are subject to hypoglycemia should be cautioned against overindulgence in ethanol, as ethanol ingestion can cause severe hypoglycemia and, in some instances, lead to coma.

Although some rare varieties of hypoglycemia, such as glycogen storage disease, may require the patient to take frequent meals to maintain the blood glucose level, other conditions may require the elimination of the offending sugar or sugar component from the diet. For example, lactosecontaining foods should be eliminated in galactosemia, a hereditary disorder of carbohydrate metabolism.

Drugs

Hypoglycemic events in patients who require insulin may be reduced or avoided by using safer insulin preparations. Long-acting insulins, such as protamine-zinc insulin or ultra-lente insulin, should be avoided because of the unpredictability of the time when they will have maximum action and the consequent risk of severe hypoglycemia.

Doses greater than 20 units per day of long-acting insulins should be avoided. Medium-acting insulins, such as NPH and lente insulin, are safer when large doses are required.

Chloropropamide should be avoided in patients with renal failure and those over the age of 70. Tolbutamide, given 5 to 10 minutes before meals, may be of some use in the treatment of hypoglycemia of the dumping syndrome, although it is usually possible to control the symptoms by diet alone.

Diazoxide may be used to inhibit endogenous insulin production in patients who have insulinomas that cannot be treated surgically.

**Emergency treatment** 

Emergency treatment of hypoglycemia involves restoration of the blood sugars to normal. This is done either by oral administration of carbohydrates, such as orange juice, or intravenous infusion of 50 percent dextrose up to 50 ml. The use of glucagon (1 mg given intramuscularly) has already been mentioned. A patient with insulinoma may require constant infusion of glucose before and during surgery.

#### References

- 1. Special Report of the American Diabetes Association. The Endocrine Society and the American Medical Association. Statement on hypoglycemia. *Diabetes* 22:2:137, Feb. 1973.
- Duncan, Garfield George. Diseases of Metabolism, 6ed. Edited by Philip K. Bondy in assoc. with Leon E. Rosenberg. Philadelphia, Saunders, 1969, p.267.
- 3. Pagliara, A.S. et al. Hypoglycemia in infancy and childhood, Pt. 1. *J. Pediatr.* 82:3:365-79, Mar. 1973.
- Wichelow, M.A. et al. Critical analysis of blood sugar measurements in diabetes detection and diagnosis. *Diabetes* 16:4:219-26, Apr. 1967.
- 5. Jacob, H.S., and Jandl, J.H. Increased cell membrane permeability in the pathogenesis of hereditary spherocytosis. *J. Clin. Invest.* 43:1704-20, Aug. 1964.
- Meites, S. and Saniel-Benrey, K. Modified glucose oxidase method for determination of glucose in whole blood. Clin. Chem. 19:3:308-11, Mar. 1973.
- Somogyi, M. Determination of blood sugar. J. Biol. Chem. 160:1:69-73, Sep. 1945.
- 8. Henry, Richard J. Clinical Chemistry: Principles and Technics. New York, Harper Row, 1967, p.634.
- 9. Hofeldt, F.D., et al. Diagnosis and classification of reactive hypoglycemia based on hormonal changes in response to oral and intravenous glucose administration. *Amer. J. Clin. Nutr.* 25:11:1193-1201, Nov. 1972.
- 10. Madison, Leonard L. et al. Evidence for a direct effect of insulin on hepatic glucose output. *Metabolism Clin. Exper.* 8:4:469-71, Jul. 1959.
- Beland, Irene L. Clinical Nursing: Pathophysiological and Psychosocial Approaches. 2ed. London, Macmillan, 1970, p.840-79.
- 12. Kintzel, Kay Carman et al. Advanced Concepts in Clinical Nursing. Toronto, Lippincott, 1971, p.125-6.
- 13. Martin, Marguerite M. Insulin reactions. Amer. J. Nurs. 67:2:328-31, Feb. 1967.

OCTOBER 1973

## Decubitus ulcer management — a team approach

A combined medical-nursing team approach has proved successful in the management of decubitus ulcer patients in Victoria Hospital, London, Ontario. This team approach was conceived by the rehabilitation nurse coordinator who, in this article, primarily describes the nursing contribution to the decubitus ulcer program.

Margaret H. Morley

In the past, there has been a tendency to lay the blame for decubitus ulcers on inadequate nursing care. This had the effect of putting the nurse on the defensive whenever a decubitus ulcer appeared on a patient under her care, and made her hesitate to report the presence of a decubitus ulcer in an early stage in the hope that the ulcer would heal.

Nurses would attempt to treat ulcers with a variety of methods and substances that had little or no scientific justification — brown soap, tineture of benzoin, heat lamps, and various antibiotic ointments. Treatment tended to change from day to day and be poorly carried out, with the result that a small ulcer would become a large one.

Physicians, on the whole, demonstrated little interest in, or knowledge of, the treatment of ulcers. Each physician had a different treatment and, in some instances, even changed it frequently. He would not follow the progress of the ulcer carefully, leaving its day-to-day management mainly to the nurse. This type of management resulted in a lengthened hospital stay and increased discomfort for the patient. Many ulcers were finally treated by plastic surgical repair.

Improved approach needed

Clearly, there was need for a better approach. We sought assistance from the department of dermatology at Victoria Hospital in treating patients with severe decubitus ulcers. When this new treatment program produced healed ulcers that previously would have been submitted to surgical repair, we realized that a great deal could be gained by applying modern methods of treatment to all decubitus ulcer patients in our hospital.

As rehabilitation nurse coordinator, I arranged a conference among the departments of physical medicine and rehabilitation, dermatology, and plastic surgery to discuss such a plan. We agreed that the working team would consist of the physiatrist, dermatologist, and rehabilitation nurse, and that the plastic surgeon would be consulted on ulcers the team felt could not be healed by medical management alone.

A detailed outline of this treatment concept was presented to the hospital's medical advisory committee, which gave its permission for a one-year trial of the proposal. A letter sent to

The author is rehabilitation nurse coordi-

nator at Victoria Hospital, London.

all members of the attending staff of Victoria Hospital asked for their cooperation in formally referring decubitus ulcer patients to the team.

#### **Oiectives**

The main objectives of the decubitus uleer team project were:

- To remove from the nursing staff the stigma of responsibility for a decubitus ulceration
- To discover all decubitus ulcers at their earliest stage and have the attending physician refer the patient to the decubitus ulcer team
- To apply modern uniform management throughout the hospital
- To supervise earefully ulcer management
- To conduct a sustained, intensive, inservice education program with the nursing and orderly staff
- To record all decubitus ulcers for statistical study

By making clear to the nursing staff that they would not be criticized if one of their patients developed a decubitus ulcer, it was possible to obtain their full cooperation in reporting all patients with impending or actual decubitus ulcerations.

The success of the entire program

THE CANADIAN NURSE 41



Fig. 1: A decubitus ulcer, on a hip, which needs to be packed with benzoyl 20% lotion.



Fig. 2: The same decubitus ulcer as in Fig. 1, after two weeks of treatment with benzoyl lotion.

depended on building a firm bond of confidence between the nursing staff and myself. This took some time, as nurses originally considered the existence of the decubitus ulcer program an infringement on their long-established custom of treating decubitus ulcers by their private methods. Patience, diplomacy, and the response of large ulcers to the new treatment eventually won all nursing staff to support the program.

#### Preventive care

Patients with decubitus ulcer potential were bathed with warm, not hot, water and a minimum of soap to avoid making the skin excessively dry. Those with dry skin were bathed with water containing a small amount of bath oil. Staff took care to avoid rubbing pressure areas with a towel. Such areas were carefully patted dry, and baby powder was applied liberally.

Patients were turned every two hours day and night, without fail. Before turning a patient, nurses removed their rings and watches in case those articles might traumatize the skin. They were careful to lift, not drag, the patient across the bed during the turning procedure, and made sure patients did not lie on rectal leads or indwelling catheters.

The head of the patient's bed was rolled up only for meals. We found that elevation of the head of the bed beyond 45° caused shearing force on the skin of the sacrum, as the weight of the patient's body pushing downward tended to abrade the epidermal surface and cause a decubitus ulcer.

Nurses reported any reddened areas or cyanosis of the skin of pressure areas, which indicated a developing decubitus ulcer. If such a change occurred, an amputation pad was placed over this area and held firmly in place by an elastic net material (Retelast).

We avoided using adhesive tape as much as possible because of the stripping damage to the epidermis produced by its frequent removal and reapplication. When tape was used, a special hypoallergenic, non-occlusive tape was ordered (Dermicel).

Foam rubber boots to protect ankles, heels, and feet proved most helpful. Sheepskins were used to protect the sacral area on some patients. Foam plastic adhesive strips (Reston) were applied to protect threatening ulcers that appeared as large bulbi.

#### Treatment of decubitus ulcers

Our decubitus ulcer program differed from standard therapy in several important aspects. The medication applied to the ulceration was a waterin-oil emulsion, containing 20 percent benzoyl peroxide lotion (Benoxyl). This is capable of killing bacteria, yeast, and fungi, but does not irritate dermal tissues.

The benzoyl peroxide lotion was applied to terry cloth cut to the size of the ulcer and moistened with normal saline. We applied the terry cloth to the ulcer, with the medicated side in contact with the ulcer surface, and then covered it with a single layer of plastic

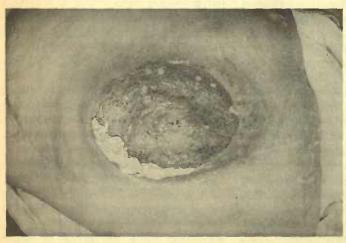


Fig. 3: Severe decubitus ulcer on buttocks area. Note packing in lower left area of the ulcer.

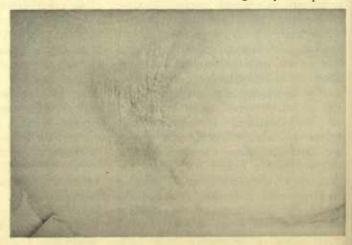


Fig. 4: Same decubitus ulcer as in Fig. 3. This ulcer is completely healed after treatment.

film. An amputation pad was placed over the dressing, with all constituents of the dressing held in place by an elastic net or body stocking of Retelast. We changed the dressing every 12 hours.

The ulcer surface was routinely cultured before starting the treatment. If the ulcer became deep or if pronounced undercutting of the skin at the periphery of the ulcer developed, one-half inch gauze packing, moistened with normal saline and covered generously with a 20 percent benzoyl peroxide lotion, was packed carefully into the depth of the ulcer, with the whole area overdressed as before.

#### Follow-up important

A most important part of the decubitus ulcer program has been the careful follow-up of each patient for the duration of his stay in hospital. As rehabilitation nurse coordinator, I made frequent rounds to see that nursing procedures were carried out with scrupulous care.

The consultants in physical medicine and rehabilitation, dermatology, and I made formal decubitus ulcer rounds once a week to see all patients receiving treatment. Because careful records are kept on all patients on the program, our weekly rounds have been invaluable in uncovering errors in management, in assessing the progress in the healing of ulcers, and in sustaining the interest of the nursing staff in the decubitus ulcer program.

#### Education for nursing staff

Lectures were held to make certain that the problem of decubitus ulceration and the concept of the new treatment were thoroughly understood by the Victoria Hospital nursing staff. The chief dermatologist and I gave these lectures together, one to the nursing administrative staff, one to registered nurses and nursing assistants, and one to the orderly staff.

We presented the causes of decubitus ulcerations, the dermatological principles governing healing of the ulcers, the rationale of the new treatment and details of its application, and the need for ceaseless vigilance night and day. We also made liberal use of color slides of actual cases. Once again, the opportunity was taken to relieve the nurse of blame for decubitus ulcers.

The physician and I encouraged questions and discussion from the audience, each of us answering questions in our own field. Results of our considerable effort were gratifying, as enthusiastic support of the program was generated throughout the patient care staff.

When first introducing the decubitus ulcer program in Victoria Hospital, some of the medical staff objected, on the basis that decubitus ulcers seldom occurred and were a minor problem.

This did not agree with the experience of the nursing staff, but an attempt to counter this objection by consulting the medical records of our hospital was not helpful. Physicians seldom included the diagnosis of decubitus ulcers on the admission and discharge form and, statistically, the problem did not exist.

How incorrect this data was is shown by the fact that 180 actual ulcers were recorded in the first year of our program's existence. Therefore, an important part of the program has been to record the diagnosis of decubitus ulcer on the patient's discharge record, so that accurate statistics will be available from year to year.

#### Results

The decubitus ulcer program began in Victoria Hospital in April, 1972. A total of 180 patients with varying degrees of decubitus ulcers have been referred to the team and, so far, only one ulcer has had to be surgically repaired. Many large complicated ulcers have been completely healed by medical management, and all patients who had ulcers and left the hospital while on treatment have been in a favorable stage of healing.

Terminal patients, whose illness had been complicated by decubitus ulceration, have been made more comfortable by the treatment described. Only one patient was unable to tolerate the benzoyl peroxide medication, because of irritation.

#### Conclusion

The most heartening result of the decubitus ulcer team program has been the change in attitude to decubitus ulcers by the hospital nursing staff. They no longer feel guilty when a decubitus ulcer develops on a patient under their care.

They report the lesion and get it under treatment at the earliest possible time. Many imminent ulcerations have been suppressed before the process has progressed to actual ulceration. Complete uniformity in ulcer management throughout the hospital has been achieved. No longer are brown soap, tincture of benzoin, and assorted other old-fashioned treatments being applied to decubitus ulcerations.

The nurse has made an important contribution to our decubitus ulcer program. Early detection and reporting of lesions by the nursing staff has greatly speeded up the application of appropriate treatment. Careful supervision of the entire program by the rehabilitation nurse coordinator has kept it moving steadily forward. Lectures to nurses, registered nursing assistants, and orderlies have heightened their interest in helping decubitus ulcer patients, and have clearly improved nursing standards.

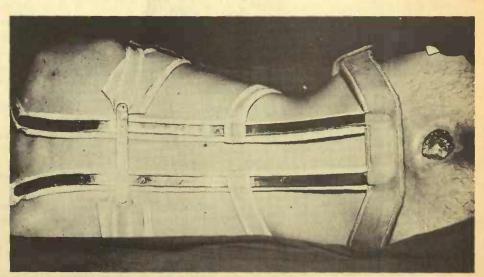


Fig. 5: A paraplegic patient wearing a brace developed this decubitus ulcer shown before treatment — in the coccyx area. The ulcer took four weeks to heal.

## Who Are These People?

People
Living one above the other
one beside the other
sharing the same address
riding the elevators alone
or should another come along
watching the lights blink out the floors
not knowing what to say
beyond a stiff "hello"

Keys jingle
the lock clicks
the door shuts
music pushes back the silence
turn it off
now listen

Elevators stop
footsteps pass
keys jingle
a door opens . . . closes
Music drifts faintly down the hall

Overhead someone's just come home
Heels echo across the floor
a tap's turned on
a bath is run
someone's doing a wash
doors shut
the fridge hums

Who are they who share the same address?
Neighbors?
Strangers?
People?

A newcomer to the city, I wrote down the sounds I heard and the feeling I experienced, alone, in an apartment. Now, no longer a stranger, I find it helpful to read what I wrote then and recall how it was to be new.

— Alma McKone, Coordinator, Inservice Education, Health Sciences Centre, Winnipeg, Manitoba.

## JRSING close-up

Mosby texts detail the full range of new nursing ideas and techniques.

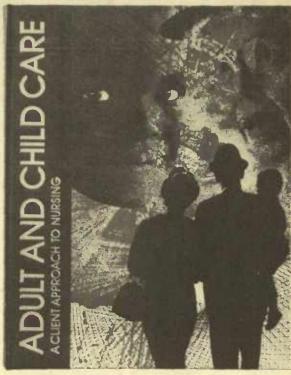
> A New Book! Barber et al

#### **ADULT AND** CHILD CARE

A Client Approach To Nursing

Nowhere is nursing's new image more apparent than in this landmark work. In an unprecedented approach, this unique text integrates the care of both adults and children according to the basic human needs of safety and security; activity and rest; sexual role satisfaction; nutrition and elimination; and oxygen. The authors set forth three steps of the nursing process that relate to each need: assessment; intervention; and instruction. Differentiating between "clients" (those assuming responsibility for their own health care), and "patients" (those receiving health care at the time of illness). the text emphasizes common, recurring problems including those in home and non-hospital settings. From this innovative "client" approach, the text stresses preventive medicine. medical-surgical advances, and rehabilitation.

The solid theoretical background provides the basis for 880 pages of highly practical procedural instruction covering hazards of development throughout the entire life cycle. The referral process for nurses involved in helping relationships;



need promotion; and the sensory, social and motor foundations of deprivation receive close attention. You'll find consideration of 20th century phenomena not often included in medical-surgical texts: artificial insemination; noise pollution; organ transplants; play therapy; genetic counseling; to name only a few. The role of the nurse in the psychological as well as physical well-being of the "client" is delineated in discussions on: crisis intervention as it relates to the "stress" pattern in illness and disaster; body image and self-concept; and the effects of hospitalization on the patient. From neonatal pediatrics to the physiologic changes of aging, this monumental work details the latest procedures and concepts and truly reflects the wide scope of contemporary nursing.

By JANET MILLER BARBER, R.N., M.S.; LILLIAN GATLIN STOKES, R.N., M.S.; and DIANE McGOVERN BILLINGS, R.N., M.S. May, 1973. 814 pages plus FM I-XVI, 8" x 10", 516 illustrations. Price, \$16.30.

> INSTRUCTOR'S NOTE: To receive a complimentary copy for firsthand evaluation, write to the Textbook Department mentioning your position, course and enrollment.



## dates

#### October 24-26, 1973

Alberta Hospital Association, annual convention, Jubilee Auditorium, Calgary, Alberta.

#### October 25-26, 1973

Rosehill Institute of Human Relations, third seminar on the application of group psychodynamic theory to management effectiveness, Inn-on-the-Park, Toronto, Ontario. For further information, write to: Conference Director, Dr. Sheldon Heath, Rosehill Institute, 1365 Yonge St., Toronto, Ont.

#### October 28-November 3, 1973

Human relations training program for inservice coordinators in the Atlantic provinces, sponsored by the nurses' associations of New Brunswick, Nova Scotia, Newfoundland and Prince Edward Island with the P.E.I. Leadership Institute of Holland College (Prerequisite: attendance at the earlier "People Power" workshop). Training program will be held in P.E.I. (location not yet settled).

#### October 29-31, 1973

Ontario Hospital Association, annual meeting, Four Seasons Sheraton Hotel, Toronto, Ontario.

#### November 4-7, 1973

Conference for nurses in staff education and staff development, Geneva Park, Ontario. For further information, write to: Registered Nurses' Association of Ontario, 33 Price Street, Toronto, Ontario.

#### November 5-7, 1973

Association of Nurses of the Province of Quebec, annual meeting, Montreal, Quebec.

#### November 6-9, 1974

The Nurses' Association of The American College of Obstetricians and Gynecologists, Ontario District V, conference, Royal York Hotel, Toronto, Ont.

#### November 11-14, 1973

Workshop on one quality control method: the nursing audit, Geneva Park, Ontario. For further information, write to: Registered Nurses' Association of Ontario, 33 Price Street, Toronto, Ontario.

#### November 13-14, 1973

Maritime Operating Room Nurses Convention, Hotel Nova Scotian, Halifax, Nova Scotia. Direct enquiries to: Ms. Mary S. Shinney, Apt. 3, 5240 Kent St., Halifax, N.S.

#### November 15-17, 1973

Canadian Public Health Association, 41st annual meeting, in association with The Tropical Medicine and International Health Division and The Canadian Association of Medical Microbiologists, Royal York Hotel, Toronto, Ontario. For further information, write to: J.C.W. Weber, Connaught Laboratories, 1755 Steeles Ave., W., Willowdale, Ontario.

#### November 16-17, 1973

Tropical Medicine and International Health Division, Canadian Public Health Association, first annual meeting, Royal York Hotel, Toronto. Persons interested in presenting papers are invited to submit abstracts of 200 words or less before September 15, 1973. For further information, write to: Secretary-Treasurer, Tropical Medicine and International Health Divison, Canadian Public Health Association, 1255 Yonge Street, Toronto 7, Ontario.

#### November 28-30, 1973

Manitoba Health Organization and incorporated sixth annual Manitoba health conference, Centennial Concert Hall, Winnipeg, Manitoba.

#### December 1, 1973

15th Conference on the Medical Aspects of Sports, sponsored by the American Medical Association, Royal

Inn, Anaheim, California. Conference theme: "Health Care for the Athlete: A Community Concern." For further information, write to: Committee on the Medical Aspects of Sports, 535 North Dearborn Street, Chicago, Illinois 60610, U.S.A.

#### February 18-22, 1974

Occupational health nursing program for registered nurses employed in the field of occupational health nursing. Fee: \$95. For further information, write to: Continuing Education Program for Nurses, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ontario.

#### April 29-30, 1974

Ambulatory Pediatric Association, 14th annual meeting, Sheraton-Park Hotel, Washington, D.C. Abstracts are invited to be considered for presentation at the scientific sessions. For further information, write to: E.S. Hillman, M.D., Montreal Children's Hospital, 2300 Tupper St., Montreal 108, Quebec.

#### May 2-4, 1974

Vancouver General Hospital 75th anniversary, gala celebration and alumni banquet, Regency Hyatt Hotel, Vancouver, B.C. For further information, write to: Executive Secretary, VGH Alumni Association, 2851 Heather St., Vancouver 9, B.C.

#### June 16-21, 1974

Canadian Nurses' Association annual meeting and convention, to be held in the Manitoba Centennial Centre Concert Hall, Winnipeg, Manitoba.



#### July 7-11, 1974

Canadian Home Economics Association, biennial convention, Vancouver, B.C. For further information write to: Ivy Turner, 4436 Price Crescent, Burnaby 1, B.C.



Mosby texts detail the full range of new nursing ideas and techniques.

New 7th Edition!

Smith

#### PRINCIPLES OF MICROBIOLOGY

Praised for its excellent organization, illustrations, and readability, this revised and updated edition concentrates on the events that take place when microbes and their products contact living human cells. After presenting basic microbiologic principles, it identifies harmful microorganisms, explains how they cause disease, and emphasizes restraints. The text includes: new chapters on immunologic reactions and metazoa; expanded material on nosocomial infections, venereal disease; and more.

By ALICE LORRAINE SMITH, A.B., M.D., F.C.A.P., F.A.C.P. June, 1973. 7th edition, 681 pages plus FM I-X, 7" x 10", 305 illustrations. Price, \$12.35.

New 3rd Edition!

Lerch New 3rd Edition!

Smith

#### WORKBOOK FOR MATERNITY NURSING

Realistically balanced between fundamentals and applications, this edition of a popular workbook provides case examples, situation-type questions, self-examinations and current references to help students correlate technical duties with personalized, family-centered nursing care. It deals with all subjects of maternity nursing including nutrition, high-risk pregnancy, the prenatal clinical, the unwed mother, and care of the neonate. Biological, physiological and psychological aspects of pregnancy and parenthood are effectively interwoven.

By CONSTANCE LERCH, R.N., B.S.(Ed.). August, 1973, 3rd edition, 194 pages plus FM I-VIII, 7%" x 10%", 37 illustrations. Price, \$5.50.

New 7th Edition!

Griffin-Griffin

Hart

#### HISTORY AND TRENDS OF PROFESSIONAL NURSING

The updated version of this classic enables students to view nursing's latest trends in historical perspective. Emphasizing the evolutionary role of women in today's society, the authors report on such current issues as: "female liberation"; abortion laws; legal aspects of nursing; research; the ladder concept; continuing education in nursing; the "nurse practitioner"; and the nurse's right to attend college under the G.I. Bill of Rights.

By GERALD JOSEPH GRIFFIN, B.S., M.A., Ed.D., R.N.; and JOANNE KING GRIFFIN, B.S., M.A., R.N.; with a special unit on Legal Aspects by ROBERT G. BOWERS, B.A., J.D. July, 1973. 7th edition, 312 pages plus FM I-XII, 7" x 10", 62 illustrations. Price, \$9.45

New 3rd Edition!

phase microscopes.

#### THE ARITHMETIC OF DOSAGES AND SOLUTIONS — A Programmed Presentation

MICROBIOLOGY LABORATORY

MANUAL AND WORKBOOK

This workbook is the ideal companion to the new 7th edition

of Principles of Microbiology - yet is readily adaptable for

use with any current text on the subject. It effectively relates

classroom theory to practical laboratory applications. Care-

fully revised and updated, this new edition spotlights the fine

points of bacteriologic technic with new illustrations and clearly demonstrates the care and use of compound and

By ALICE LORRAINE SMITH, A.B., M.D., F.C.A.P., F.A.C.P. June,

1973. 3rd edition, 172 pages plus FM I-VIII, 74" x 101/2". Price,

Totally reworked and reworded for greater clarity and accuracy, this concise, programmed approach actively involves students in the learning process, while allowing them to proceed at their own rate. Information is arranged in logical order; each step builds on the one before; answers to each problem appear at the end of the exercise. A refresher on fractions, decimals, percentages, and ratios is included as well as information on pediatric dosages and expanded discussions of insulin and I.V. fluid flow.

By LAURA K. HART, R.N., B.S.N., M.Ed., M.A., Ph.D. April, 1973. 3rd edition, 76 pages plus FM I-VIII, 7" x 10". Price, \$4.15.

TIMES MIRROR

INSTRUCTOR'S NOTE: To receive a complimentary copy for firsthand evaluation, write to the Textbook Department mentioning your position, course and enrollment.

THE C. V. MOSBY COMPANY, LTD. • 86 NORTHLINE ROAD, TORONTO, ONTARIO M48 3E5

## in a capsule

Law against smoking?

The Journal, published by the Addiction Research Foundation of Ontario, reported in July 1973 that the government of India is considering legislation to prohibit smoking in the country.

This legal ban was suggested by the Indian Association for Chest Diseases and the Tuberculosis Association of India. However, government officials have not said how this type of law could be enforced.

#### Skiers beware

Before long, skiers will be turning their thoughts to the slopes. First, though, there is the question of whether to make do with last year's equipment or head for the nearest ski shop. For beginners, it means being faced with a bewildering assortment of skis, fittings, poles, boots, and so on.

A warning about the widely used plastic ski boot was given by a physician at the Bronx Municipal Hospital Center in New York. G.L. Crelinsten, in a letter to the editor of *The New England Journal of Medicine* (February 22, 1973), offered the following observations:

"The orthopedic surgeon has become well aware of the marked increase in serious lower-leg fractures due to the newly popular high, stiff, plastic ski boot. Many skiers who escape fracture may also fall prey to the new boot. After a hard day of challenging the mountain and of spending many frustrating minutes in long lift-lines, the skier will complain of irritating numbness and tingling of the soles of the feet. This dysesthesia detracts from the après ski fire and hot mulled wine. The cause of this syndrome is not simply thawing feet, but probably pres-

sure neuropraxia of S<sub>1</sub> sensory fibers at the boot top, akin to ulnar-nerve neuropraxia due to prolonged elbow pressure. Ski-boot neuropathy is a benign affliction and serves to remind the enthusiast of his recent battle with nature."

#### Foot mirrors diseases

According to an internationally known foot specialist, the foot is a mirror of many constitutional diseases. The first signs of diabetes, pernicious anemia, neurological diseases, and even brain tumors are sometimes revealed in the foot, Dr. Marvin Steinberg said in Hamilton, Ontario, last August.

Dr. Steinberg, director of the department of podiatry at Jewish Memorial Hospital in New York, was speaking at the annual scientific conference of the Canadian Podiatry Association. He told his audience that his years of research in detecting malignant lesions and treating skin growths and tumors associated with foot pain have convinced him of the importance of diagnosis in treating foot problems.

He noted that the first indication of rheumatic fever in children often manifests itself with pain in the children's heels. Dr. Steinberg also demonstrated new treatments for gout and arthritis of the feet, and said podiatric research is being conducted on melan-

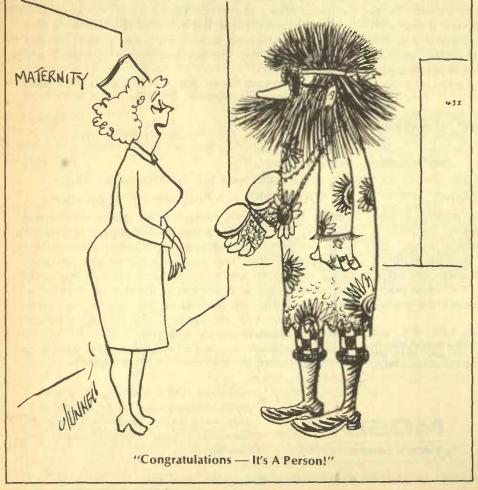
oma and arthritis of the foot.

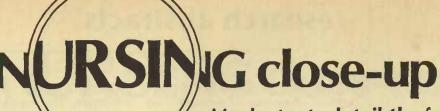


The Patent Office in Ottawa regularly sends out its *New Patents News*, which gives up-to-the-minute information on innovations ranging from hats that hide hair curlers to a method of salvaging beached or sunken marine vessels.

One of the interesting items in April's patent news concerned the problem of documents being photocopied without permission. This problem could be solved by the Xerox Corporation of Rochester, New York.

According to our news source, "Canadian Patent 917,701, granted to the Xerox Corporation on December 26, 1972, discloses a way of coating a document with a light-emitting material, making it readable to the human eye but unreadable to a photo-copying machine. It would seem the photocopiers have finally foiled their own invention."





Mosby texts detail the full range of new nursing ideas and techniques.

A New Book!

Auld-Birum

A New Book! McCalister et al

#### THE CHALLENGE OF NURSING A Book of Readings

This broad overview incorporates philosophical, conceptual, and practical aspects of nursing. Articles chosen from original publications by more than thirty nursing leaders discuss such stimulating topics as: the definition and nature of nursing; psychological diagnosis; adaptation of nurses to their profession; and the nurse's involvement in her work. Patient needs are stressed throughout.

By MARGARET E. AULD, B.S., M.N., R.N.; and LINDA HULTHEN BIRUM, B.S., M.N., R.N.; with 38 contributors. January, 1973. 247 pages plus FM I-XIV, 6½" x 9½". Price, \$5.20.

READINGS IN FAMILY PLANNING A Challenge to the Health Professions

Accented with professional and personal overtones, this unique approach challenges students to increase the effectiveness of health care in the vital area of family planning. Twenty-eight articles integrated via skillful introductions discuss all facets of family planning including the disparity between who needs and who uses it; birth control techniques; development of community family-planning programs; and more.

By DONALD V. McCALISTER, B.A., Ph.D.; VICTOR THIESSEN, B.A., M.A., Ph.D.; and MARGARET McDERMOTT, R.N., B.S.N., M.S.N., Ph.D.(Candidate). March, 1973. 256 pages plus FM I-XII, 7" x 10". Price,

New 5th Edition!

Squire-Welch A New Book!

#### BASIC PHARMACOLOGY FOR NURSES

In a practical outline form, this text supplies vital information on the effects, dosages, and usages of common drugs; and notes weights, measurements and abbreviations used in medicine. Chapters new to this edition discuss: anesthetics; hallucinogenic drugs; serums and vaccines; and antineoplastic drugs. It features an arithmetic review section, full glossary, topic area assignments and an answer booklet.

By JESSIE E. SQUIRE, R.N., B.A., M.Ed.; and JEAN M. WELCH, R.N., A.B., M.A., B.S., N.Ed. March, 1973. 5th edition, 370 pages plus FM I-XII, 7%" x 10%". Price, \$6.05.

READINGS IN GERONTOLOGY

A multi-disciplinary approach to gerontology, this work illustrates the relationship between theory, research and practice. Sociological, developmental and emotional factors are emphasized. Articles discuss nutrition; management of grief and suicide; research; functional assessment of the elderly; the effects of aging on activities and attitudes; and many often neglected aspects of gerontology.

Edited by VIRGINIA M. BRANTL, Ph.D.; and SISTER MARIE RAYMOND BROWN, R.S.M., M.N.Ed. July, 1973. 118 pages plus FM I-X, 6" x 9". Price, \$4.15.

A New Book!

**Butler-Lewis** 

Vukovich-Grubb A New Book!

#### AGING AND MENTAL HEALTH -Positive Psychosocial Approaches

This new text explores economic and everyday problems of elderly Americans. Comprehensive in coverage, the authors stress late life as a normal process emphasizing mental health factors and intervention in both institutional and noninstitutional settings. The text features a detailed discussion of illness prevention.

By ROBERT N. BUTLER, M.D.; and MYRNA I. LEWIS, ACSW; foreword by ARTHUR S. FLEMMING, Chairman, White House Conference on Aging. May, 1973. 308 pages plus FM I-XIV, 7" x 10", 26 illustrations. Price, \$6.25.

#### CARE OF THE OSTOMY PATIENT

This book provides guidelines for understanding the specific needs of ostomy patients and the behavioral and physical problems encountered in their return to a productive life. Beginning with the normal digestive tract, it shows progressively how the body develops problems leading to ostomy surgery. Diagnosis, tests and surgeries are discussed as well as diet, medications and appliances.

By VIRGINIA VUKOVICH, R.N., E.T.; and REBA D. GRUBB, Medical Writer; foreword by DONALD G. SHRDPSHIRE. August, 1973. 138 pages plus FM I-XIV, 6" x 9", 23 illustrations by TRAVIS L. MAYHALL. Price, \$5.55.

> INSTRUCTOR'S NOTE: To receive a complimentary copy for firsthand evaluation, write to the Textbook Department mentioning your position, course and enrollment.



THE C. V. MOSBY COMPANY, LTO. . B6 NORTHLINE ROAD, TORONTO, ONTARIO M4B 3E5

Next Month

## Canadian Nurse

- Smoking Now and Then
- Nurse Involvement in Medical Education
- Detoxification: an Alternative in Transition



## Photo credits for October 1973

St. Mary's Hospital, Montreal, p. 35

Dept. of Visual Medical Records and Education, Victoria Hospital, London, Ontario, pp. 42, 43

#### research abstracts

Pearen, Elsie I.E. A survey of Canadian schools of nursing to determine the instruction and clinical experience provided in mental retardation. Vancouver, B.C., 1973. Thesis (M.S.N.) U. of British Columbia.

This descriptive study was done to provide information on the number of hours of theory and clinical experience students received during nursing education that might equip them with skills required for mental retardation nursing. Registered nurses associations for each province assisted in the study by providing lists of nursing schools in their province. Of the 142 nursing schools having a graduating class in 1969, 140 were studied. The urgency of the problem was shown when it was noted that an estimated three percent of the population of Canada were mentally retarded.

Several commissions have been done on this topic in the past decade in Canada. Some studies of this general nature have been done in the United States. Review of the literature indicated that no previous studies had been done on this topic in Canada.

A questionnaire was constructed to obtain data relating to placement of mental retardation experience, hours of theory and clinical experience provided, and the year of nursing education in which the experience occurred. Questionnaires were mailed to the schools, completed by them, and returned.

Diploma schools tended to provide between 0 to 8 hours of theory and clinical experience in mental retardation, whereas university schools tended to offer up to 12 hours of experience. Most nursing education in mental retardation occurred in pediatrics or psychiatric programs, or in combinations of these and other courses. Mental retardation nursing education tended to occur in the next to the last year of the program for all schools. Many schools, however, indicated that mental retardation experience was not included in the school curriculum.

It appeared that little theory and clinical experience in mental retardation was being given students enrolled in nursing schools in Canada. The relative lack of planned clinical experience with retarded individuals was surprising.

Several problems and limitations were encountered in conducting the study, particularly concerning data

collection and the tool used tor data collection. The data had to be collected in two phases from two different sources — home schools and affiliated schools — to obtain accurate data.

From the findings, it appears that:

Studies could be done to focus at-

tention on current problems in nursing the mentally retarded, related to the need for inclusion of theory and clinical experience in the curriculum of nursing schools.

• Studies could also be done to determine time allotment, placement, and specific mental retardation content in current nursing programs.

• Qualitative studies could be done to show the possible effect of staff knowledge of mental retardation on the care provided to mentally retarded patients.

Valentine, Patricia Ellen B. Professionalism in nursing. Calgary, Alta., 1973. Thesis (M.A.) University of Calgary.

This research is concerned with the examination of professionalism in Alberta nursing during the past half century. The concepts of profession and professionalization are briefly discussed in relation to professionalism; and three components of professionalism (knowledge-skill, autonomy, ideological) and their empirical indicators are examined, using the historical method.

Broadly speaking, some findings suggest that there has been an increase in the degree of professionalism in nurses in Alberta, with the trend becoming more apparent in the 1960s when there were appreciable increases in many of the indicators.

The knowledge-skill component shows that, although there have been increases in the majority of the indicators, research, more specifically research in the substantive area of nursing, has been neglected.

The autonomy component suggests that Alberta nurses have been making increasing gains in attaining autonomy. However, having two separate bodies responsible for nursing standards and the lack of "politicization" of Alberta nurses may be impeding the further development of professionalism.

The ideological component's one indicator suggests that tender loving care, a value strongly associated with nursing, is being neglected by nurses in Alberta.



A New Book!

Bryan

#### SCHOOL NURSING IN TRANSITION

For an up-to-date picture of school nursing philosophy, current practices and patterns of administration, consult this new book. It delineates the role of the school nurse in relation to children, parents, community, and school workers and emphasizes the need for new nursing techniques to increase the effectiveness of school health services. Specific guidelines are given for developing and administering programs as well as for the core nursing procedures involved in delivering health services.

By DORIS S. BRYAN, R.N., M.P.H., Ph.D. November, 1973. Approx. 288 pages, 57 illustrations. About \$9.40.

A New Book!

#### A GROUP APPROACH IN NURSING PRACTICE

This new book provides the reader with a clear understanding of group process, leadership and methods as well as the therapeutic potential of groups. It describes the scope of group work in nursing and illustrates the theoretical frameworks that guide study and practice in this area. Informative discussions consider group psychotherapy and groups formed for therapeutic, growth, reference and self-help purposes. Helpful group studies demonstrate nursing intervention.

By GWEN D. MARRAM, R.N., B.S., M.S., Ph.D. May, 1973. 220 pages plus FM I-XII, 6" x 9". Price, \$5.80.

Marram A New Book!

**Bevis** 

#### CURRICULUM BUILDING IN NURSING: A PROCESS

This volume is directed toward the educator interested in developing a new nursing curriculum or modifying an existing one. It provides essential educational theory and then makes direct applications to the special needs of the nursing curriculum. Topics considered include: future nursing functions: learning strategies; task groups; educational environments; health environments; student and faculty characteristics; evaluation methods; and much more.

By EM OLIVIA BEVIS, R.N., B.S., M.A. August, 1973. 172 pages plus FM I-XII, 7" x 10", 34 illustrations in 28 figures. Price, \$7.10.

A New Book!

#### NURSING AND THE PROCESS OF CONTINUING EDUCATION

This book of readings provides a convenient reference to available resources, designs, methods of implementation, learning aids, and innovations which have proven successful in continuing education programs for nurses. The opening chapters define continuing education in nursing and explain institutional, governmental and individual roles. Other discussions provide guidelines for program need assessment, procedures for design and implementation, and methods to evaluate courses, participants, and staff.

Edited by ELDA S. POPIEL, R.N., B.S., M.S.; with 32 contributors. July, 1973. 248 pages plus FM I-XX, 6½" x 9½". Price, \$7.30.

A New Book!

Treece-Treece

#### ELEMENTS OF RESEARCH IN NURSING

In a practical, how-to-do-it manner, this new work offers clear, concise explanations for each step of the research process. Essential data necessary for developing research projects plus maximum utilization of available resources are only two of the book's innovative highlights. The relationship between theory and method is treated in depth. Valuable tips for research and how to write, report and publish research findings are included.

By ELEANOR WALTERS TREECE, R.N., B.A., M.Ed., Ph.D.; and JAMES WILLIAM TREECE, Jr., B.R.E., B.A., M.A. June, 1973. 284 pages plus FM I-XII, 7" x 10", 56 illustrations. Price, \$9.75.



## books

Report of the Special Study Regarding the Medical Profession in Ontario by Edward A. Pickering. 193 pages. Toronto, Ontario Medical Association, 1973.

Well-written, clear, and succinct, the report concerns itself with the role of the medical profession in present day society, how relationships between doctors and government may be improved, the relative economic position physicians should occupy, and the method by which the physicians' fee schedule might be modified. The recommendations in all four areas are sensible and none are unexpected.

The bonus in this book is the two reports attached as appendixes. One was prepared by Peter Ruderman of the University of Toronto's school of hygiene, who is not a physician; it describes the economic position of Ontario physicians and the relation between the fee schedule and actual income from fee practice. It is interesting not only in its findings but in the description of the process by which the comparisons were made.

The other report appended is a background paper on citizen participation by Thelma McCormack of the York University department of sociology.

This is a gem of clarity.

It poses questions about the purpose of citizen participation. "Is the goal of citizen participation social change or is it to develop new information systems within an established social order?"

Rarely has a report been so readable and so credible. Nurses from all provinces should find this study interesting.

Cardiovascular Disorders: Patient Care by Pat Ashworth and Harry Rose. 309 pages. London, Baillière, Tindall, 1973.

Reviewed by Basanti Majumdar, Assistant Professor, School of Nursing, McMaster University, Hamilton, Ontario.

The purpose of this book is "to help nurses understand and enjoy their work with patients suffering from cardiovascular diseases, be it in special units, in general wards, or in the patient's own

This book is designed "for trained

nurses working with these patients, for the more senior nurses working towards their final examinations and subsequent registration" and for the specialist in cardiovascular nursing.

It is written in such a manner that nurses will not have to read through the whole book to find information on

a particular topic.

In the first chapter the author presents the table, issued by the World Health Organization, listing death rates from heart conditions. The data shown in the table is from 1955 to 1967. The reviewer is disappointed that more up-to-date data is not pro-

The discussion of different heart conditions includes anatomy, physiology, signs and symptoms, and management of the patient: investigations, drugs, surgery, doctors' and nurses' "acts." It includes the importance of good team work between surgeon, physician, nursing staff, other para-medical staff, and family. The author does not discuss in depth the effect of heart disease on family and society as a whole. The emphasis is more on how the disease affects the individual. Occasionally, the same information is given in several chapters.

This book would be a valuable resource for both the practicing nurse and the student. It may not be appropriate for the specialist in cardiovascular nursing; she may find it too limi-

ted a reference source.

Basic Pharmacology for Nurses, 5ed. by Jessie E. Squire and Jean M. Welch. 370 pages. Saint Louis, Mosby, 1973.

Reviewed by Carol Batra, Associate Professor, School of Nursing, University of Windsor, Windsor, Ont.

This paperback is updated from 1969 and is intended to be used in a 45- to 60-hour pharmacology course. It is reorganized to encourage the student in self-help study and testing.

The authors stress that this text is for briefer nursing courses, to give a working knowledge of basic pharmacology to the student. The material is presented in concise, point form and an extensive background in the sciences is not a prerequisite.

The revisions and additions made in the text are particularly in its reorganization and better integration of problems with the material presented. There are more conversion problems with stress on solving problems by ratio method. There are a few additional drawings of syringes along with many new drugs presented, particularly anesthetics, serums and vaccines, antineoplastic and hallucinogenic drugs.

The book has an accompanying answer booklet and a brief but up-to-date bibliography for each chapter. The material is presented in the traditional method of drug dosages and problems for one-third of the text, followed by drugs affecting the various body systems for the remaining two-thirds of

the text. This book would be useful as a text for student self-study or as an adjunct to a basic course in pharmacology. Its strength lies in its concise and clearlywritten format, which is suitable for quick reference for a particular type of dosage problem or for a class of drugs. The questions with each chapter frequently involve only recall of the chapter content but include some clinical situations. A weaker student might need more practice problems in the drug dosage sections. More advanced courses would demand much greater depth and physiological explanation of the drugs mentioned. Also, in Canada, one would appreciate reference to the Canadian drug legislation. Drug dosages for children, milli-equivalent doses, the unit dose system, and charting of medications were, however, all omitted in the text.

In summary, I feel the authors have improved on their previous editions and have presented a basic text for the beginning student, for self-study, or for a brief review.

Concepts Basic to Nursing by Pamela Holsclaw Mitchell. 470 pages. Toronto, McGraw-Hill Ryerson, 1973. Reviewed by Sheila B. Embury, Professional Associate, School of Nursing, University of Calgary, Calgary, Alberta.

This book is an introduction to professional nursing for students being prepared as primary agents of nursing

OCTOBER 1973

care. "It is based upon the premise that the professional nurse is the practitioner who determines the need for nursing care, plans the care, gives or directs its implementation and evaluates the efficacy of the care." The author presents a systematic approach to the nursing process and a conceptual approach to practice. Although most textbooks dealing with the "fundamentals" of nursing are oriented to the care of the hospitalized sick person, this book was conceived for nursing care in any setting.

Theories of health and illness are presented as a frame of reference for the focus of nursing. The description of the changing role of the nurse within today's social, cultural, and health care systems will enable the student to design effective nursing plans and use appropriate strategies for each patient. The nursing process is covered in great detail under the following topics: interpersonal relationships, the scientific method, the process of diagnosis, and planning nursing care.

Basic nursing knowledge is related to specific body functions, but is covered under the concepts of maintenance of functional ability, prevention of disability, and provision of sustenance and comfort in the face of health problems. In relation to each specific body system, the chapter begins with a list of pertinent data the student can use as a means of assessing patient needs. Following a detailed description of the topic, there is a summary of common problems and suggested approaches.

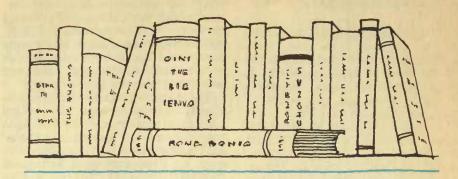
This book is an exciting approach to basic nursing content. It introduces the student to the nursing skill of conceptualizing knowledge as an efficient means of organizing, storing, and retrieving information. The depth with which subject matter is presented will make this a useful textbook for first-

year nursing students.

Respiratory Intensive Care Nursing by Sharon Spaeth Bushnell. 354 pages. Boston, Little, Brown, 1973. Canadian Agent: Lippincott, Toronto. Reviewed by Jean E. Fry, Lecturer in Nursing, School of Nursing, Mc-Master University, Hamilton, Ontario.

In the preface to this book, the author states that her purpose in writing it is "to present current interdisciplinary practices in respiratory and intensive care . . . . It is intended for nurses who are caring for critically ill patients, teaching such care or organizing intensive care facilities.'

The author has focused on symptoms, causes, and treatment of respiratory and related disorders, presenting



underlying anatomical and physiological bases for these disorders, as well as generally accepted preventive and corrective measures. She has shown laboratory procedures, observational skills, and respiratory measurements complement one another in determining diagnosis and subse-

quent treatment.

As modes of treatment, she has considered drug therapy, use of mechanical equipment, oxygen therapy, and physiotherapy, as well as skillful nursing care, and has shown how each of these has a specific role to play either singly or in combination. She discusses prevention of respiratory impairment by positioning the patient and outlines required nursing care and precautions to observe when various types of mechanical equipment are used to establish the airway and to maintain its patency.

Both physical and psychological aspects of nursing care of patients in respiratory intensive care units are discussed, including implications for

relatives, visitors, and staff.

In viewing roles and relationships of the various members of the respiratory team, Ms. Bushnell has shown how each member has a unique and vital service to offer in providing effective patient care and treatment.

Included in the chapter on monitoring is a discussion of safety precautions, particularly relevant in these days of complex electrical monitoring equipment, the safety of which is all too readily taken for granted Mode of transport of the critically ill patient and organization of a respiratory surgical intensive care unit are also discussed. Helpful addenda contain relevant definitions, symbols and values, the gas laws, and ranges of normal laboratory values.

While much of this material can undoubtedly be found in various texts, this one small volume, conveniently ringed to lie flat, provides the up-todate material most required in critical care areas. Although she states in her preface that it is not meant to be a procedure manual, in certain instances, it could be that as well.

This book should prove a handy manual for reference in any specialized care area (ICU, CCU, or respiratory

Review of Nutrition and Diet Therapy by Sue Rodwell Williams. 293 pages. St. Louis, Mosby, 1973.

Reviewed by Carolyn Pepler, Faculty of Nursing, University of New Brunswick, Fredericton, N.B.

The author has presented a review of nutrition in a clear, concise, questionand-answer format that is readily readable. The emphasis throughout is on nutrition as a science and approximately four-fifths of the book is devoted to normal nutrition and metabolism in the healthy person. In this respect the inclusion of "diet therapy" in the title may be misleading, although principles of

diet therapy are included.

It differs from some of the usual textbooks on nutrition for nurses in that there is more (or as much) detail of biochemistry and physiology throughout the life cycle and less information about meal planning, recipes, or the preparation and serving of food. The author has been able to present the scientific principles quite fully and yet simply, and has used diagrams effectively so that a background in these sciences is not essential. Inasmuch as the nurse reader would have some understanding of the theory and terminology of chemistry and biology, the author meets her objective in providing a review of nutrition and metabolism. For the beginning student, concurrent study of the other sciences would be helpful as the material is comprehensive but brief.

In the section on "Community Nutri-

#### books

tion," principles of psychology and sociology are given as the base for understanding the why of dietary habits and the how of teaching people to change them if necessary. Guidelines for interviewing and assessment of nutritional status are included.

The section on health problems and clinical nutrition is succinct with principles of diet therapy following through from pathophysiology. The author has appropriately selected only those common conditions in which diet

therapy plays a major part.

This book would be useful as a basic text for nursing students. It would help students relate content from the physical, biological, and behavioral sciences to therapy and nursing practice. One major disadvantage to its use as a textbook is the omission of references in the body of book. There is a short general list at the end. At the depth presented, the chemical and biological material is, to the best of present knowledge, fact rather than theory; however, some of the sociological and psychological content is theory rather than fact. It is unfortunate that the author did not mention the theorists.

The book would also be valuable in ward or agency office libraries, but it is not a quick reference for suggested

menus!

Saunders Tests for Self-Evaluation of Nursing Competence, 2ed., by Dee Ann Gillies and Irene Barrett. 392 pages. Toronto, Saunders, 1973. Reviewed by Sue Rothwell, Instructor and Consultant, Continuing Education, University of British Columbia, Vancouver, B.C.

The idea of self-evaluation in nursing is not new; nursing educators have fostered a situation in which nursing students use compendiums of patient problems and questions to prepare themselves for licensure examinations. Many are familiar with the first edition of this book. The second edition has added 15 new patient problems.

The four sections in the book follow the test areas of licensure examinations. Each section contains a series of patient problems labelled according to medical diagnosis. The reader is presented with short patient situations, followed by questions asked in a repetitious format, testing for factual knowledge about pathophysiology, a familiarity with medical treatment, rudimentary knowledge of pharmacology, and the rationale for nursing interventions.

Although the psychologic aspects of obstetrics and gynecology are deemphasized, the bibliography following has some excellent references. Pediatrics provides insufficient opportunity for evaluating an understanding of growth and development, and one completely loses the sense of family.

The medical-surgical problems emphasize pathophysiologic facts at the expense of patient teaching and nursing interventions to relieve patients' and families anxiety. Here the references are disappointing as well, since they rarely refer to the good nursing literature on the psychologic aspects of physical illness. Only the barest essentials of patient follow-up and preventive health care are included. Rarely does one move beyond the therapeutic use of self to planning for patient care in

the psychiatric section.

This second edition has avoided the common, but educationally offensive, practice of preceding each section by a watered-down summary of the content area to be covered. For those who quickly involve themselves in the patient situation, there is an anxiety-reducing summary of the patient's resolution at the completion of each situation. The summary sometimes strains reality, as in the case of the chronic alcoholic who leaves the hospital with his multivitamins and, presumably, the purest of intentions after "his physician and nurse had taught him the importance beverages." of avoiding alcoholic Would that it were so easy!

Although the authors of self-evaluation tests often express lofty intentions

**Nursing History References** 

Several copies of three basic historical nursing references are available to schools of nursing libraries for their collections, on a first come, first served basis for the payment of postage. These texts are:

Canadian Nurses' Association publications: A proposed curriculum for schools of nursing in Canada, Montreal, 1936, and A supplement to proposed curriculum for schools of nursing in Canada, Montreal,

1940.

A survey of mursing education in Canada by George M. Weir, Toronto, University of Toronto Press, 1932.

To request these texts, write to The Librarian, Canadian Nurses' Association, 50 The Driveway, Ottawa, Ontario K2P 1E2.

of involving students in analyzing patient data and synthesizing principles, the student's purpose in using the text rarely goes beyond gaining skill for answering the multiple-choice questions of licensure examinations.

This text should not be used by students whose need for preparation extends beyond skill acquisition to principles of growth and development, communication, and interpersonal relations. Its hardcover binding suggests that it will not be used by students whose income is below poverty levels. Who is left?

Continuing Nursing Education by Signe Skott Cooper and May Shiga Hornback. 261 pages. Toronto, McGraw-Hill Ryerson, 1973.

Reviewed by Marie A. Loyer, Associate Professor and Coordinator of Continuing Education, University Of Ottawa, School of Nursing, Ottawa, Ontario.

The underlying principle that guides this book is: education is a lifelong process. The book is written "for nurses who are responsible for planning and administration of continuing education in nursing, and for those who teach in such programs." It addresses itself particularly to faculty members of institutions of higher learning but can also be useful to inservice personnel.

The short history focuses attention on the newness of the concept of continuing education in nursing. It is interesting to note that the first international conference on continuing nursing education took place under the leadership of Margaret Neylan of U.B.C. during the I.C.N. Congress

in Canada, in June 1969.

Though the focus is on continuing education in nursing, the authors recognize that continuing education is also concerned with the development of the nurse as a person, and as a citizen. Self-directed learning and a personal commitment of the individual learner is a basic requirement. On this principle programs are planned, objectives developed, nurses are involved in their own learning, and motivation is sustained.

Nurse faculty members will find this book valuable because it reviews clearly and succinctly principles of learning and teaching strategies, defines teaching methods and short term courses, and gives a comprehensive guide to workshop planning, as well as a sample format for grant proposals.

The administrator and faculty member should become familiar with the scientific studies briefly referred to in the fifth chapter. Knowledge of theory would guide the teacher in preparing

OCTOBER 1973

the learners to meet their needs in the most effective way. Each chapter offers selected, recent documentation and is well referenced.

The authors appeal for better coordination and planning of programs. Another primary consideration is the need for adequate financial support, effective planning and use of resources, and appropriate evaluation. These are well documented in the text and should be respected by those concerned with continuing education in nursing.

This book is recommended for use by administrators and faculty members because it brings together principles of administration, education, and psychological foundation applied to continuing education in nursing.

The Challenge of Nursing: A Book of Readings by Margaret E. Auld and Linda Hulthen Birum. 247 pages. St. Louis, Mosby, 1973.

Reviewed by Myrtle E. Crawford, Associate Professor of Nursing, University of Saskatchewan School of Nursing, Saskatoon, Sask.

This is another book of articles collected from a number of sources. Anthologies of this sort are becoming increasingly numerous in nursing literature. This is definitely one of the better collections. The list of 38 contributors includes some of the most able and bestknown nursing authors. The advantage of a collection such as this is that, instead of having to search through a dozen journals, the articles are all in one place.

The bulk of the articles are from journals that are likely to be in the average nursing library - American Journal of Nursing, Nursing Outlook, Nursing Clinics of North America, International Nursing Review, and The Canadian Nurse — but there are also several articles from journals not as likely to be found in a personal or average library; there is, in addition, a paper by one of the editors that was previously unpublished.

The 33 articles are grouped into five sections or units. These units could be the basis of a course outline for an introductory class in nursing. The original purpose of the editors in compiling the readings was for use in such a class. In their words, "The selections were carefully chosen to provide the reader with a broad overview of nursing."

The editors suggest the readings might be used by students formulating career goals, nursing educators, nursing students at any level of preparation, and nurses who wish to keep current in their profession, to provide "a philosophical, conceptual, and practical viewpoint of nursing." Each unit has a short introduction by the editors stating the purpose of the unit and giving a brief overview of each reading.

It is difficult within the scope of a review to single out individual articles for comment. Several of my favorites are present. Some excellent ones I had not previously noticed have been brought to my attention. Really, every reading is worthy of attention by the concerned nurse, although I imagine the book will most often be used by the reader scanning the table of contents or flipping the pages looking for a particular article on a special topic. This, too, is a valid use of the book.

With its soft cover and moderate size, the book is easy to carry around and is relatively easy on the pocketbook. It is worthy of a place in personal, school, and agency libraries.

#### AV aids

#### LITERATURE AVAILABLE

A catalog of resources produced by Mediascience Limited, 742 Bay Street, Toronto, Ont. M5G 1N6, is available in an attractive ring binder, 8 1/2 inches by 5 1/2 inches. The catalog, divided into subject sections, gives resumés and other relevent information about the videotape cassette programs on health sciences, available for sale or rental from Mediascience.

As tapes are previewed by Mediascience staff and reviews written and printed, Mediascience will provide more information, which can be easily added to the binder. Space is provided for cross reference notes at the end of each subject section.

Questions or requests for this catalog should be sent to Marilynne Seguin at Mediascience. The catalog can be borrowed from the CNA library.

#### FILMS

The following films are available on loan from the library of the Addiction Research Foundation of Ontario, 33 Russell Street, Toronto, Ontario M5S 2S1.

Alcohol (16mm, sound, color, 13 minutes) was produced by Moreland-Latchford Productions Ltd., Toronto, in 1972. The subject of this film is heavy drinking in the business world.

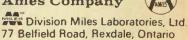
Bitter Wind (16mm, sound, color, 35 minutes), produced in the United States in 1966, shows what alcoholism does to a Navajo Indian family. The

### The least you can do for hospitalized diabetics

It's not that you should do more. It's just that KETO-DIASTIX\* Reagent Strips require the least amount of effort in testing for glucose and ketones in urine. Simply dip into urine and get a semiquantitative reading for glucose and ketones in 30 seconds. What could be easier and less troublesome for you and the patient? Useful all around the hospital. On wards, at the bedside, in patient teaching centers, and in the O.P.D. Also, a good test to recommend for the patient to use at home after discharge. Obtain full details on KETO-DIASTIX by calling your Ames Systems Specialist or by writing to the address below. It's the least work you can do in diabetic urine testing.

## **Keto-Diastix**

Ames Company



"Chamical and biological information systems



story of the family's problems is told by the eldest son, who tries to begin a new life for the family.

#### accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, except reference items, may be borrowed by CNA members, schools of nursing and other institutions. Reference (R) items (Archive books and directories, almanacs and similar basic books) do not go out on loan. These are on Reserve and may go out on Interlibrary loan only.

Request for loans should be made on the "Request Form for Accession List" and should be addressed to: The Library, Canadian Nurses' Association, 50 The Driveway, Ottawa, Ont. K2P 1E2.

No more than three titles should be requested at any one time.

#### BOOKS AND DOCUMENTS

- 1. A.L.A. cataloging rules for author and title entries. 2ed. Edited by Clara Beetle. Chicago, American Library Association, Division of Cataloging and Classification, 1970. 265p.
- 2. Abrégé de médecine préventive et d'hygiène, par G. Blancher. Paris, Masson, 1972.
  3. Activists and nonactivists: a psychological study of American college students, by Larry C. Kerpelman. New York, Behavioral, 1972. 162p.
- 4. Allergy; a layman's guide to sneezing, wheezing and itch, by Allan Knight. Don Mills, Ont., Burns and MacEachern, 1973. 171p.
- 5. Being a creative faculty member is more than... teaching. Report of the 1972 workshops. New York, National League for Nursing, Council of Diploma Programs, 1973. 74p.
- 6. La biologie; les êtres vivants. Paris, Gérard, 1973. 679p. (Dictionnaires marabout université, v.8).
- 7. Body, mind, and sugar, by E. M. Abrahamson, and W. W. Pezet. New York, Pyramid Books, 1971. 240p.
- 8. British health centres directory, 1973, compiled by Brian Brookes. London, King Edward's Hospital Fund for London, 1973. 233p. R
- 9. Canadian resources on the family; catalogue. Ottawa, Vanier Institute of the Family, 1972. I vol.
- 10. Cancer: horizons nouveaux. Publié sous la direction de Jean-Louis Léger et al. Ottawa, Association des Médecins de Langue française du Canada, 1973, 428p.
- 11, Challenge to community psychiatry; a dialogue between two faculties, Division of

Community and Social Psychiatry, Columbia University and Division of Psychiatry, Boston University, by Institute for Training in Community and Social Psychiatry, Boston, 1968. Edited by Archie R. Foley. New York, Behavioral, 1972. 203p.

- 12. Communicating nursing research: the many sources of nursing knowledge. Edited by Marjorie V. Batey. Boulder, Colorado, Western Interstate Commission for Higher Education, 1972. 208p.
- 13. Concept formalization in nursing; process and product, by Nursing Development Conference Group. Boston, Little, Brown, 1973. 226p.
- 14. The critical issues of community mental health, by Harry Gottesfeld. New York, Behavioral, 1972. 296p.
- 15. Death and the college student. Edited by Edwin S. Shneidman. New York, Behavioral, 1972. 209p.
- 16. Deviant behaviour and societal reaction, edited by Craig L. Boydell et al. Toronto, Holt, Rinehart and Winston, 1972. 627p.
- 17. Dossier GM1A 1-3. Montreal, Centres de Formation des Gardes-Malades et Infirmiers auxiliaires, 1968. 3 vols.
- 18. Drogues, société et option personnelle, par Harold Kalant et Oriana Josseau Kalant. Traduit de l'anglais par Pierre de Léan. Montréal, La Presse, 1973. 215p.
- 19. Familiar medical quotations, by Maurice Benjamin Strauss. Boston, Little, Brown, 1968. 968p. R
- 20. Familiar quotations; a collection of passages, phrases and proverbs traced to their sources in ancient and modern literature, by John Bartlett. Emily Morison Beck, editor. 14ed., rev. and enl. Boston, Little, Brown, 1968. 1750p. R
- 21. La femme au Québec, par Marcelle Dolment et Marcel Borthe. Montreal, Presses Libres, 1973. 158p.
- 22. Final report of the Lancet Commission on Nursing. Appointed in Dec., 1930 to inquire into the reasons for the shortage of candida-

tes, trained and untrained, for nursing the sick in general and special hospitals throughout the country, and to offer suggestions for making the service more attractive to women suitable for this necessary work. London, The Lancet Ltd., 1932, 256p. R

- 23. Forty-ninth session of World Health Organization, Executive Board, Geneva, 18-27 January 1972. Geneva, World Health Organization, 1972. 2 vols. (WHO Official records no. 198 and 199) R
- 24. From Nightingale to eagle; an army nurse's history, by Edith A. Aynes. Englewood Cliffs. N.J., Prentice-Hall, 1973. 318p. 25. Hospital officers' training course. Ottawa, Canadian Penitentiary Service, 1972. 1 vol. R 26. Human resources as the wealth of na-
- Oxford University Press, 1973. 173p. 27. The infertile period; principles and practice, by John Marshall. rev. ed. Baltimore, Helicon Press, 1968.

tions, by Frederick H. Harbison. New York,

- 28. Jeunes enfants à l'hôpital, par James Robertson. Traduction de Madeleine Botton et Annie Mignard. Paris, Centurion, 1972. 158p.
- 29. A journey of wonder and other writings, by Dorothy M. Jupp. New York, Vantage Press, 1971. 248p.
- 30. Kingston General Hospital; a social and institutional history, by Margaret Angus. Montreal, McGill-Queen's Univ. Press, 1973. 205p.
- 31. Labour economics in Canada, by Sylvia Ostry and Mahmood A. Zaidi. 2ed. Toronto, Macmillan, 1972. 354p.
- 32. Lecture accélérée de l'ECG; un enseignement programmé par Dale Dubin. 2éd. Traduit en français par Eric Mazan et J. F. Delzant, Paris, Maloine, 1972, 268p.
- 33. The life of Mary Wortley Montagu, by Robert Halsband. New York, Oxford University Press, 1960. 313p.
- 34. Lillian Wald; neighbour and crusader, by R. L. Duffus. New York, Macmillan, 1938. 371p.
- 35. Major modalities in the treatment of drug abuse, edited by Leon Brill and Louis Lieberman. New York, Behavioral, 1972.
- 36. Master catalogue. Toronto, International Tele-Film Enterprises, 1972, 180p. R
- 37. Medical subject headings—alphabetic list, 1973, by National Library of Medecine. Springfield, Va., National Technical Information Service, 1972. 686p.
- 38. Methadone: experiences and issues, edited by Carl D. Chambers and Leon Brill. New York, Behavioral, 1973. 411p.
- 39. Le micro-massage chinois et les techniques qui en dérivent, par Jacques-A. Lavier. 2éd. Paris, Maloine, 1970. 100p.
- 40. The New York Times guide to reference materials, by Mona McCormick. New York, Popular Library, 1971. 224p.
- 41. Notes used on catalog cards; a list of examples, compiled by Olive Swain. 2ed. Chicago, American Library Association, 1970, c1963. 82p. R
- 42. Nutrition and your mind; the psychochemical response, by George Watson. New York, Harper and Row, 1972. 170p.

#### INDIA

18 days, package from \$628.00 (Includes return fare).
Optional tours to Ceylon and Nepal available.

Return airfare to India \$463.00 Ex. Montreal.

MANILA (Lowest return airfares)
From San Francisco - \*\$425.00
From Toronto \*\$660.00
Montreal - \$702.00

\* \* Subject to Gov't approval

Low one-way fares to Europe and Far East.

For details and reservation, contact:

UNITED TRAVELS, LTD., 2 College St., Suite 105, Toronto, Ont. Telephone (416) 964-1706 In Montreal Tel.: 871-8022 43. Papers presented at Canadian Hospital Association National Convention, June 2-4, 1971, Montreal. Toronto, 1971. 1 vol.

44. Peoplemaking, by Virginia M. Satir. Palo Alto, Calif., Science and Behavior Books, 1972. 304p.

45. La pratique de la méthode sympto-thermique de régulation de la fécondité dans la région de Québec, par Sonia Cazes et André Lux. Québec (ville) Université Laval, 1972.

46. Principles of medical science, by Ralph Goldman. New York, McGraw-Hill, 1973.

47. Proceedings of the one hundred and fifth annual meeting of Canadian Medical Association, including the transactions of the general council, Montreal, June 14-16, 1971. Ottawa, 1972. 110p.

48. Psychiatric nursing in the hospital and the community, by Ann C. Burgess and Aaron Lazare. Englewood Cliffs, N.J., Prentice-Hall, 1973. 427p.

49. Psychological aspects of planned parenthood. London, International Planned Parenthood Federation, Europe Region, 1972. 60p. 50. Report of Medical Library Association 1972-73. Chicago, 1973. 130p.

51. The SREB project in nursing education 1967-1972, by Helen C. Belcher. Atlanta. Ga., Southern Regional Education Board, 1972. 127p.

52. Special study regarding the medical profession in Ontario; a report to the Ontario Medical Association, by Edward A. Pickering. Toronto, Ontario Medical Association, 1973. 1 vol.

53. Stock color masters, vol. 8. Spencer, N.Y. n.d. 1 vol. R

54. Study papers to assist in the formulation of a policy position on manpower training. Prepared for the Manpower Programs Committee, the Council of Ministers of Education, Canada. Toronto, Systems Research Group, Inc., 1972. 1 vol.

55. The successful secretary's handbook, by Esther R. Becker and Evelyn Anders. New York, Harper and Row, 1971. 418p.

56. Textbook of medicine for nurses, by Winnifred Hector in association with G. Hamilton Fairley. 2ed. London, William Heinmann, 1973. 456p.

57. World health statistics annual. Vol. 3: Health personnel and hospital establishment, 1969. Geneva, World Health Organization, 1973. 251p. R

58. Yearbook of drug abuse, edited by Leon Brill and Earnest Harms. New York, Behaviorial, 1973. 386p.

#### AMPHLETS

19. The employment interview - techniques of questioning. Swarthmore, Penna., The Personnel Journal, 1970. 15p.

0. A guide for selecting an administrator. Edmonton, Alberta Hospital Association, 973. 14p.

1. Husband, father, humanitarian, specialist, urse. New York, National League for Nursng, 1972. pam.

2. Manual of information for the preparation

and utilization of nursing care plans. Vancouver, B.C., Registered Nurses' Association of British Columbia, 1973. 15p.

63. Standards for nursing services, health agencies, nursing homes, industry, schools, ambulatory services, and related health care organizations. Kansas City, Mo., American Nurses' Association, Commission on Nursing Services, 1973. 8p.

64. Stop smoking - by keeping track, by Kenneth V. Hertz. Montreal, Ingluvin, 1971.

65. Study papers to assist in the formulation of a policy position on manpower training; summary report. Prepared for the Manpower Programs Committee, the Council of Ministers of Education, Canada. Toronto, Systems Research Group, Inc., 1972. 37p.

66. A usually reliable source, by Donald Phillipson. Ottawa, Canadian Science Writers' Association, 1973, 37p.

67. Utilization review: some directions. New York, National League for Nursing, Council of Home Health Agencies and Community Health Services, 1973. 25p.

#### GOVERNMENT DOCUMENTS

Canada

68. Dept. of the Solicitor General. Report 1971/72. Ottawa, Information Canada, 1972.

69. Economic Council of Canada. An overview of CANDIDE (Canadian Disaggregated Inter Departmental Econometric) model 1.0, by M. C. McCracken. Ottawa, 1973. 337. (CANDIDE Project paper no. 1)

70. Labour Canada. Labour standards. Ottawa, 72. 1 vol.

71. -. Women's bureau 1972. Ottawa, Information Canada, 1973, 41p.

72. National Research Council of Canada, Committee on Scientific Criteria for Environmental Quality. Inventory of Pollutionrelevant research in Canada. Interim Report compiled by R.M.D. Sutton and C. Quadling. Ottawa, 1972, 1 vol.

73. Science Council of Canada. Health care in Canada: a commentary. Background study for the Science Council of Canada, by H. Rocke Robertson. Ottawa, 1972. 2 vols. R

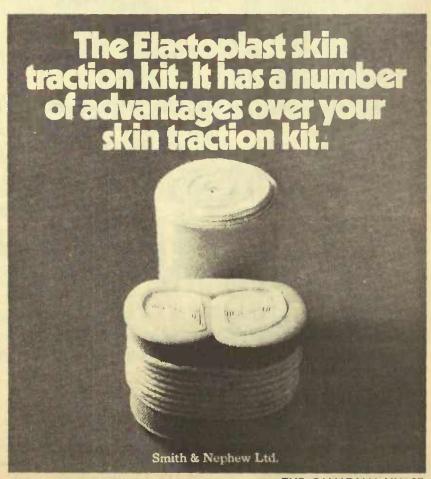
74. Statistics Canada. Enrolment and staff in schools for the blind and the deaf, 1972/ 73. Ottawa, Information Canada, 1973. 11p. 75. —. Notes on labour statistics, 1972. Ottawa, Information Canada, 1973. 94p.

76. - Pension plans in Canada, 1970. Ottawa, Information Canada, 1972. 73p.

77. —. Statistical information on schools of social work in Canada, 1971. Ottawa, Information Canada, 1973. 26p.

78.—. Statistical profiles of educational staff in community colleges, 1970/71. Ottawa, Information Canada, 1972. 65p.

79. —. Statistics of private elementary and secondary schools 1971/72. Ottawa, Information Canada, 1973. 7p.



#### accession list

Quebec

80. Commission of Inquiry into the Status of the French Language and Language Rights. Resume of the report of the Commission, volume 1. Quebec, Business Linguistic Centre, 1973. 63p.

81. Ministère de l'Education. Direction générale de l'enseignement collégial. CEGEP 1973. Québec, 1973. 40p

82. Ministère des Affaires Sociales. Direction de la Recherche et de la Statistique. Medias. Optique de Programme. Québec, P.Q., 1972. 24p.

United States

83. Bureau of Health Manpower Education. Division of Nursing. Special project grants awarded for improvement in nurse training. A listing, July 1972. Bethesda, Md., for sale by U.S. Govt. Print. Off., Washington, D.C., 1973. 129p. (DHEW Publication no. (N1H)

84. Dept. of Health, Education and Welfare. Library. More words on aging; a bibliography of selected 1968-1970 references compiled for the Administration on Aging by

the Department Library. Washington D.C., for sale by the Supt. of Docs., U.S. Govt. Print. Off., 1971. 107p.

85. -. Words on aging; a bibliography of selected annotated references compiled for the Administration on Aging by the Department Library. Washington, D.C., for sale by the Supt. of Docs., U.S. Govt. Print. Off., 1970. 190p.

86. National Center for Health Statistics. Administrators of nursing and personal care homes: education and training, United States - June-August 1969. Washington, D.C., Public Health Service, 1973. 71p. (Vital and health statistics series 12, no. 18)

87. —. Current estimates; from the health interview survey United States 1971. Washington, D.C. Public Health Service, 1973. 69p. (Vital and health statistics series 10, no. 79) 88. National Institutes of Health. Social and psychological aspects of applied human genetics: a bibliography, by James R. Sorenson. Bethesda, Md., Fogarty International Center; for sale by U.S. Supt. of Docs.,

lication no. (NIH) 73-412) 89. — Status of immunization in tuberculosis in 1971. Report of a conference on progress to date, future trends and research needs. Edited by Earl C. Chamberlayne. Bethesda, Md., 1971, 252p.

Washington, D.C., 1973. 98p. (DHEW Pub-

90. - Report of National Library of Medicine 1972. Bethesda, Md., 1972. 56p.

91. -. Bureau of Health Manpower Education. The foreign medical graduate: a bibliography. Washington, D.C., U.S. Govt. Print. Off., 1972. 107p. (DHEW Publication no. (N1H) 73-440)

92. —. Clinical Center. Nursing care of the manic depressive patient. Bethesda, Md., 1973. 18p.

93. Public Health Service. The health consequences of smoking. Bethesda, Md., 1973. 381p.

94. Secret Service. Physical Fitness program. Washington, D.C., U.S. Govt. Print. Off., 1972. 28p.

STUDIES DEPOSITED IN CNA REPOSITORY COLLECTION

95. Description of New Hampshire's first orientation-training program for family planning personnel by Nancy Garrett. Ann Arbor, Mich., 1971. 18p. R

96. Nurse practitioners in primary care by Walter O. Spitzer and Dorothy J. Kergin, M.A. Yoshida et al. Ottawa, Canadian Medical Association, 1973. I vol. R

97. Nursing supply and future requirements, Nova Scotia, by Dorothy Thomson and Peter C. Gordon. Halifax, Registered Nurses' Association of Nova Scotia, 1973. 76p. R

98. Patient classification system and staffing by workload index; a working manual. Saskatoon, Sask., Saskatchewan University, Hospital Systems Study Group, 1973. 30p. R

#### Request Form for "Accession List"

#### CANADIAN NURSES' ASSOCIATION LIBRARY

Send this coupon or facsimile to: LIBRARIAN, Canadian Nurses' Association, 50 The Driveway, Ottawa, Ontario. K2P 1E2. Please lend me the following publications, listed in the ....................... issue of The

Canadian N	Nurse, or add my name to the waiti	ng list to receive them when available:	
Item No.	Author	Short title (for identification)	
************			
Requests for loans will be filled in order of receipt.  Reference and restricted material must be used in the CNA library.			
Borrower .		Registration No.	
Position .			
Address .			
Date of re	equest		

# The Canadian Nurse

November 1973

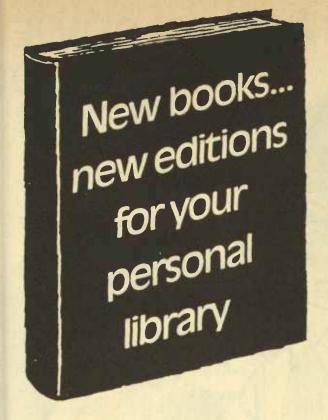




DO NOT TAKE

### FASHION LIGHTS UP YOUR CAREER **BEAM IN ON** WHITE SISTER **FASHION IN ACTION** #41430 5-15 Sizes \$25.00 White about J# 41430 Pale Blue, Navy, about \$26.00 #41371 #41371 Sizes 5-15 About \$28.00 SEE OUR DEALER LISTING IN SEPTEMBER ISSUE.





#### New-CRITICAL CARE NURSING

By Carolyn M. Hudak, R.N., M.S., Barbara M. Gallo, R.N., M.S., and Thelma Lohr, R.N., M.S.

This book's holistic approach is based on the interrelation of the major body systems—respiratory, cardiovascular, renal and nervous—with man's needs as a framework. Holism is explained in terms of physiological considerations for crisis nursing and emotional response to illness. Anatomy, physiology and pathophysiology, management modalities and assessment skills are discussed in relation to the major body systems. Nursing practice in the critical care unit is examined, including staff training and development and legal responsibilities.

### New—Student Work Manual in CRITICAL CARE NURSING

500 pages/1973/about \$9.95

Provides questions and answers to major units of *Critical Care Nursing*. Recommended for review and self-testing in conjunction with the text.

about 90 pages/perforated and punched/1973/paperbound, about \$2.75

#### New (2nd) Edition

#### INTRODUCTORY MATERNITY NURSING

By Doris C. Bethea, R.N., M.S.

The expanded role of the practical/vocational nurse in obstetric care and maternal-child nursing is reflected in this new edition. The physical and psychosocial dimensions of normal and abnormal motherhood are thoroughly discussed. New chapters include "Maternity Care Today," "The Family and Pregnancy," "High-Risk Mothers and Infants," and "Evaluating the Fetal Condition." Updated material is included on abortion, drug addiction and other matters of current social concern.

276 pages/illustrated/1973/paperbound, \$4.95

### New (2nd) Edition FOUNDATIONS OF PEDIATRIC NURSING

By Violet Broadribb, R.N., M.S.

This edition of a well-known book by an experienced nurse clinician has been broadened to include recent findings in child psychology, advances in pediatric medicine and surgery. You will find new material on psychosocial development, genetic factors, the child in the family, intensive newborn care, and pediatric pharmacology. Organization is by age—birth to adolescence. The Appendix contains preparations for laboratory tests, common pediatric procedures, and a section on pediatric drugs, dosages, action and effects.

500 pages/illustrated/1973/paperbound, \$7.95/clothbound, \$9.95

#### New-MATERNAL-CHILD NURSING

By Violet Broadribb, R.N., M.S., and Charlotte Corliss, R.N., M.Ed.

Family-centered in approach, this text covers the entire maternity experience, and child care from birth to adolescence. Delinquency, drug abuse and similar problems of the older child are thoroughly discussed. Information on homemaker services, family planning clinics and parent education is included. Questions and answers follow each unit.

700 pages / 1973 / \$12.25

#### New—CARE OF THE OLDER ADULT

By Joan Birchenall, R.N., M.Ed., and Mary Eileen Streight, R.N., B.S.N.

A valuable text in an increasingly important area of health care for the practical/vocational nurse. Content includes the older person in the family and society; developmental tasks; community aspects; housing, health, nutrition, recreation; normal aging; nursing in long-term facilities. Restorative nursing is emphasized.

250 pages/1973/paperbound, \$4.75

Serving the Health Professions in Canada since 1897									
J. B. Lippincott Company of Canada Ltd., 75 Horner Ave., Toronto, Ont. M8Z 4X7									
Please send me the following books:									
☐ CRITICAL CARE NURSING about \$9.95	Name								
Student Work Manual in CRITICAL CARE NURSING about \$2.75	Position								
☐ INTRODUCTORY MATERNITY NURSING	Address								
paperbound, \$7.95 clothbound, \$9.95	City								
MATERNAL-CHILO NURSING									
CARE OF THE OLDER ADULT\$4.75	ProvincePostal Code								
☐ Payment enclosed ☐ Use my Chargex									
Books may be returned within 15 days	CN-11-73								



### The Canadian Nurse



A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 69, Number 11

November 1973

17 The Nurse in a Student
Physician's "Practice" B. Valberg, D. Corbett

22 Smoking Now and Then N. Garrett

23 Detoxification: An Alternative
in Transition F.D. Funston

30 Genetic Manipulation: Now is the
Time to Consider Controls L. Siminovitch

The views expressed in the editorial and various articles are those of the authors and do not necessarily represent the policies or views of the Canadian Nurses' Association.

4 Letters

36 Names

7 News

38 Books

15 Dates

40 Accession List

Executive Director: Helen K. Mussallem • Editor: Virginia A. Lindabury • Assistant Editors: Liv-Ellen Lockeberg, Dorothy S. Start • Editorial Assistant: Carol A. Dworkin • Production Assistant: Elizabeth A. Stanton • Circulation Manager: Beryl Darling • Advertising Manager: Georgina Clarke • Subscription Rates: Canada: one year, \$6.00; two years, \$11.00. Foreign: one year, \$6.50; two years, \$12.00. Single copies: \$1.00 each. Make cheques or money orders payable to the Canadtan Nurses' Association. • Change of Address: Six wecks' notice; the old address as well as the new are necessary, together with registration number in a provincial nurses' association, where applicable. Not responsible for journals lost in mail due to errors in address.

Manuscript Information: "The Canadian Nurse" welcomes unsolicited articles. All manuscripts should be typed, double-spaced, on one side of unruled paper leaving wide margins. Manuscripts are accepted for review for exclusive publication. The editor reserves the right to make the usual editorial changes. Photographs (glossy prints) and graphs and diagrams (drawn in india ink on white paper) are welcomed with such articles. The editor is not committed to publish all articles sent, nor to indicate definite dates of publication.

Postage paid in cash at third class rate MONTREAL, P.Q. Permit No. 10,001. 50 The Driveway, Ottawa, Ontario. K2P 1E2

Canadian Nurses' Association 1973.

The case of the tobacco leaves

Early in October, I visited a county fair in the southern part of Ontario. While browsing about the various buildings on the fair grounds, I came across a surprising exhibit — several glassed-in cases of tobacco leaves decked with ribbons depicting first, second, and third prizes. These tobacco-leaf displays had been submitted by members of the local 4-H club.

I find it strange, indeed disturbing, that these young people are being encouraged to grow tobacco and are being awarded prizes for producing the "best" tobacco leaves. And I find it appalling that the 4-H club — a nation-wide club that is akin to cleanliness and godliness in the eyes of many — allows its members to exhibit tobacco leaves. Rather, I would expect the 4-H club, which stands for Head, Heart, Hands, and Health, to be teaching its members about the hazards of tobacco and smoking.

True, the mere growing of tobacco "does not a smoker make"; however, it is safe to say that anyone who grows tobacco will never see it as a product which, when smoked, is harmful to his health and to the health of others.

More about tobacco

Tobacco growing is big business in Canada. Consider these facts released by the Ontario Flue-Cured Tobacco Growers' Marketing Board:

More than 4,500 tobacco farms are registered with the Ontario Board.

☐ Each tobacco farm has an average size of 30 acres.

These farms "will generate more than 150 million dollars in total sales this year."

Tobacco, next to western wheat, is Canada's 'largest single agricultural export commodity.'

These tigures show why the tobacco lobby in Canada is so powerful. Many tobacco farmers refuse to harvest other crops, which are less lucrative, and the federal and provincial governments are loathe to encourage change, as this would eliminate the high taxes they now reap on tobacco sales.

However, be not despondent. While the federal government is sweeping this tobacco revenue into its gargantuan coffers, it is, at the same time, giving away (read "spending") our money to a noble cause: the fight against the smoking of tobacco.

### letters

Letters to the editor are welcome.

Only signed letters, which include the writer's complete address, will be considered for publication.

Name will be withheld at the writer's request.

Questions re electrical hazards

I would like to suggest that nurses direct their questions or problems to *The Canadian Nurse*. If *CNJ* staff cannot answer the question, perhaps readers may be able to help, I have a

problem I'd like answered:

Recently, in reading about electrical hazards, I was unable to find a concise definition of "the electrically sensitive patient." Does this include a patient with a simple IV, or is a direct path to the heart necessary? Does a CVP line make a person electrically sensitive?

I enjoyed reading articles in the September 1973 issue, particularly the article "Cardiac surgery in the first person." — Nora Briant, RN, Corner

Brook, Newfoundland,

NRC officer replies

According to John A. Hopps, senior research officer, medical engineering group of the National Research Council: "The electrically sensitive patient is one with a conductive pathway to the heart. This pathway is usually a catheter containing conductive saline, a dye solution, or wires. As terms tend to become ambiguous, classifications are moving away from emphasis on the patient, toward emphasis on the environmental risk. For example, an angiography procedure is classified as a high-class risk."

MD replies to OR nurse

From the contents of the letter "OR nurse is puzzled" (Aug. 1973, p.5) it has to be presumed that if the different shifts and the hospital OR routines are to flow smoothly, only those nurses who do not have "little whims" will be acceptable for positions they are adequately trained and qualified to occupy. Either that or their "queeziness" in assisting to destroy innocent human life must be put aside!

So far I have had no proof of any overt discrimination taking place in the hiring of nurses or any other medical personnel. However, I have written to MPs in Ottawa and to MLAs in this province of the possibility of such subtle practices taking place at present or in

the future.

I admire the courage of this nurse. I hope that if any such discriminating practices become obvious, complaints will be submitted to the provincial nurses associations. If no aid is forth-coming from these organizations, the human rights bureau of the provincial government should be contacted.

I hope many more members of our two professions, dedicated to the maintenance of the moral ethics of practice, will come forward and voice, loudly, their displeasure at this horrible carnage taking place in our Canadian hospitals I also hope the Canadian Nurses Association will se to it that its members, who wish to uphold the rights and respect for all human life, are not discriminated against.

The so-called medical reasons for these abortions are depression and/or anxiety in 99.9 percent of cases. Abortion does not cure either of these; in many cases, it worsens the condition.

MOVING?

Be sure to notify us six weeks in advance, otherwise you will likely miss copies.

**BEING MARRIED?** 

Attach the Label From Your Last Issue OR

Copy Address and Code Numbers From It Here

NEW (NAME) /ADDRESS:

Street

\_\_\_\_

City

Prov./State

Please complete appropriate category:

I hold active membership in provincial nurses' assoc.

Zone

reg. no./perm. cert./ lic. no.

I am a Personal Subscriber.

MAIL TO:

The Canadian Nurse 50 The Driveway OTTAWA, Canada K2P 1E2 It is utterly sickening that some members of our professions can so crassly perpetrate violence against the most innocent and helpless of our charges — the unborn infant. — Peter C. Mendes, M.D., F.R.C.P.(C), Edmonton, Alberta.

Reply to letter on abortion

I am writing in reply to a letter to the editor, "OR nurse is puzzled," signed by "RN, Alberta" (August 1973, page 5). I am not a Catholic, but there are

times I almost wish I were.

I fail to see how the medical profession can condone and even be in agreement with so-called "abortion on demand"; this is not something that has to do with the life of the mother, but just another way of getting rid of another unwanted pregnancy.

How can a doctor surround an elderly dying patient with all the paraphernalia of survival, when the person would rather die with dignity, and then perform an abortion on a mother?

God help us. What are we, as members of a medical profession dedicated to saving lives, becoming? I have nursed proudly for 28 years. I am almost ashamed now to be part of a profession that has reached such a casual attitude toward life and death. — Constance Crumb, RN, Berwyn, Alberta.

School closing after 67 years

St. Paul's Hospital School Nursing regretfully announces the impending closure of the school in September 1974, after 67 years of operating.

We hope to bring together as many as possible of our 3,829 graduates for a special final event. The last graduation ceremonies — for the 1974 class — will be held on Sunday, June 2, 1974, at 2:00 P.M. at the Queen Elizabeth Theatre. This will be a good opportu-

nity for a get-together.

The Alumnae Association would be pleased to hear from those who would like to take part in a special event on this occasion. Nothing specific has been arranged as yet. Please address all correspondence to: Ms. D. McLellan, Alumnae President, #29 — 4550 Fraser Street, Vancouver, B.C. — M. Whitney, R.N., B.S.N., Assistant Director. School of Nursing.

NOVEMBER 1973



### **Double-Tex** Surgeons' Gloves

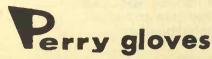


Need extra protection against slippage when you're handling slippery metal, glass and plastic surgical instruments? Try Perry's Double-Tex\* sterile, surgical gloves with light, velvet-textured palms.

You'll also get another exclusive Double-Tex feature. A special textured interior surface. Designed to protect against "in-the-glove slippage" caused by perspiration build-up during long procedures.

Double-Tex's strong, but thin, palm prevents binding. In addition, specially designed, curved fingers make Double-Tex a comfortable glove that is not fatiguing during long procedures.

Available in white and brown latex. Sizes 5½ through 9. Packaged in convenient peeldown, nonresealable outerwrap. Innerwrap provides a 276 square inch sterile field. Double-Tex. Just what you asked for and just from Perry.



A PRODUCT OF

AFFILIATED MEDICAL PRODUCTS LIMITED
90 Commercial Avenue, Ajax, Ontario

#### news

#### **Basic Health Care Changes Needed** Nurse Tells Physicians' Meeting

Ottawa — Members of the Royal College of Physicians and Surgeons were told September 21, 1973, that nurses have a valuable contribution to make in influencing individuals' life-style and environment. This opinion was expressed by Jane Henderson, associate executive director of the Canadian Nurses' Association.

The CNA representative, who addressed the Ontario regional meeting on the "Future of Health Care for Canadians," said, "Unless we are concerned about the personal and environmental aspects of our clients' lives, we are not

truly interested in health."

She explained that "if we know ill health will result from certain activities, it is our responsibility to intervene." For example, she said, smoking, eating and drinking in excess, or less than a certain minimum of physical activity are thought to contribute to cardiovascular disease.

The speaker noted. "While we ensure an appropriate nutritional intake inside the hospital, we must work to eliminate the national malnutrition problem, which exists in spite of our denials.'

On the subject of maternal and neonatal care, she asked: "Why do we tolcrate double standards..., one for urban areas and another for inner city and remote areas?" The reason for this, she answered, is "because we are still content to provide 'medical care.' According to this definition, care is where a doctor is.'

CNA's associate executive director also said that a change in the "service personnel mix" is inherent in the pro-

vision of health services.

She noted that the phrase "medical care" almost by definition means a doctor providing services with or without those who are known as "para-medical assistants." On the other hand, she added, "health care" refers to a group that gives care on a colleagual basis, with each member contributing from and diagnosing within his area of competence. But "cach member relies on and respects the special contribution of other members of the total care

The speaker explained further: "If what we are providing is medical care,

#### Guess Who's Coming To Lunch?



Guest at a working luncheon held during the July 9 meeting of the Economic Council of Canada was Prime Minister Pierre Trudeau. He is pictured with André Reynaud, left, chairman of the Economic Council, and Helen K. Mussallem, executive director of CNA and a member of the Council. Dr. Mussallem is the first health professional among the 25 Council members.

then the doctor alone may diagnose. If, on the other hand, we can accept the concept of health care, several categories of practitioners may diagnose.

'In other words, as we broaden the definition of care from one centered on pathology to one concerned as well with life-style and environment, we simultaneously broaden the definition of diagnosis.

**B.C. Senior Citizens Receive** Instruction In Home Nursing

Vancouver, B.C. — A St. John Ambulance experiment in Vancouver and Victoria has shown the benefits that can result from providing senior citizens with home nursing and first aid skills.

The experiment involved 220 senior

citizens, ranging in age from 65 to 91 years, in a course that lasted from January to June, 1973. Instruction was given in personal health, nutrition, community resources, body mechanics, body defense mechanisms, heart disease, home treatments, and first aid.

One conclusion drawn from this project is that senior citizens trained in home nursing and first aid skills are better able to care for themselves. This is seen as a major financial saving by keeping the elderly self-reliant for a longer time; enabling earlier discharge from hospitals; preventing accidents through safety awareness; ensuring greater confidence in emergencies; and creating awareness of resources available from community agencies.

The second conclusion St. John

THE CANADIAN NURSE 7

officers have drawn is that senior citizens can provide knowledge and skills in the community by visiting others and by their greater awareness of the needs of ailing friends who require care.

Support for this project came from a Local Initiatives Program grant and from the health authorities of the federal, provincial, and municipal governments. St. John Ambulance provided the administration, instruction, and materials.

Because of the success of the experiment, St. John Ambulance in British Columbia is seeking support from the provincial government for another sixmonth study, which would involve 1,000 senior citizens in five urban centers. A second L.I.P. grant is also being requested from the federal government.

ANPQ Committee Working On Plan For Nursing Education In Quebec

Montreal, Que. — An ad hoc committee recently set up by the Association of Nurses of the Province of Quebec is working on a "plan for nursing education" in Quebec. It held its first meeting September 17 and 18, 1973.

The committee, which is examining the objectives of the professional nursing programs at the university and college levels and in health institutions, will present an official statement on nursing education in March 1974. Continuing education, as well as basic educational programs, are being studied.

Earlier this year, a joint committee that studied continuing education in Quebec submitted a proposal to ANPQ, entitled "A Plan for Nursing Education in Quebec." This proposal, together with a request from the department of education to examine education at the college level, led to the formation of the ad hoc committee. The joint committee was composed of members of the school of nursing at MeGill University and the nursing departments of Dawson, Vanier, and John Abbott colleges—the three English-language colleges in the province.

The joint committee's proposal pointed to the need for a mechanism to be built into the educational process to ensure flexibility, since the systems of health care and education continually evolve. This flexibility would ensure that a student could not only "progress through different levels within the educational pattern she originally selects, but also that she [could] opt to transfer into the alternative pattern of study," the committee said.

Pointing out that some CEGEP graduates will be seeking access to the bacealaureate program, and that at present "there is little similarity between the CEGEP nursing program and the health sciences (pre-university) program in the CEGEP," the joint committee stated that serious consideration should be given to:

• restructuring the basic CEGEP nursing program, giving the students more options to increase the number of courses accepted for credit toward the health sciences diploma, and to encourage potential university applicants to select electives with academic credit; and

• emphasizing the need for counseling students in high school so they enter the basic nursing program appropriate to their ambition and potential.

The committee also suggested that university schools of nursing undertake practical research programs to answer the following questions:

• What is the nature of the nursing performance of the CEGEP nursing graduates who apply?

• How do the CEGEP nursing graduates go about learning?

• What type of program, based on the needs of the CEGEP nursing graduates,

will assist them to meet the goals of the B.Se.N. program?

• How will the progress of these grad-

uates be assessed as they proceed through the B.Sc.N. program?

As well as referring to becaleureate

As well as referring to baccalaureate nurses studying at the graduate level, the committee's proposal noted that "many baccalaureate graduates in arts and science are seeking a eareer in nursing."

The importance of incorporating a number of these arts and science graduates in the health professions was emphasized. However, rather than enrolling them in the B.Sc.N. program, the committee proposed "that they enter a qualifying year to learn the fundamentals of nursing and then proceed into the master's program where they would expand their practice of nursing, specializing either as a nurse elinician or as a researcher."

Nova Scotia Nurses Make Gains In 1973 Collective Agreements

Halifax, N.S.—Negotiations by staff nurses' associations in Nova Scotia for contracts in 1973 have been drawn out, but they have resulted in increased salaries and improvements in sick leave, vacations, and other benefits.

The delay in negotiating contracts began with a wait for passage of the health budget in the provincial legislature. Following this was a fight by nurses to obtain as much as teachers received. Finally, five hospital nurses' groups signed contracts giving the nurses increases of eight percent for 1973 and seven percent for 1974 for all elassifications.

As soon as these contracts were signed, unrest became apparent among Civil Service nurses in Halifax and Dartmouth hospitals (News, October 1973, page 8). After mass resignations, these nurses won a salary increase that surpassed — by \$38 — the salary recommended for 1973 by the Registered Nurses' Association of Nova Scotia.

This was the first time nurses in the province attained the salary their professional association recommended for them. RNANS has recommended a basic salary of \$8,000 for 1974; however, the increase in 1974 for Civil Service nurses will give them a basic annual salary of \$7,817.

Other gains the Civil Service nurses have won include an increase in standby pay from \$5 for 24 hours to \$5 for 8 hours; a vacation of 4 weeks after 5 years, instead of 4 weeks after 15 years; and adjustments in numbers of consecutive days of work, overtime, and weekends.

At Aberdeen Hospital in New Glasgow, a much disliked sick leave formula has been deleted. Vacations have been improved to four weeks after seven years, and an extra holiday added to the existing nine.

Negotiations by staff associations at eight Cape Breton hospitals are not yet settled. The associations have requested conciliation. A staff association at The Halifax Infirmary was certified September 18 and planned to start negotiations on its first agreement this fall.

There are now 19 certified staff nurses' associations in the province, and one more is awaiting certification. Another three groups are organizing.

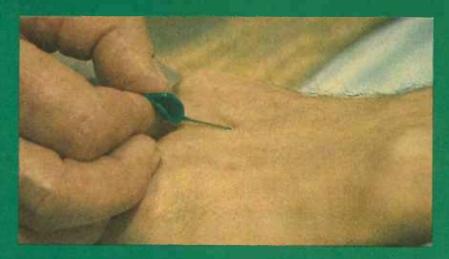
#### Keynote Speaker At ARNN Meeting Has Advice For Associations

St. John's, Nfld. — Professional associations in the future will have an increasingly important role to play if they adopt long-range goals relevant to their members' changing needs and to the community-at-large.

Helen K. Mussallem, executive director of the Canadian Nurses' Association, made this prediction October 1, 1973, during her keynote address at the annual meeting of the Association of Registered Nurses of Newfoundland.

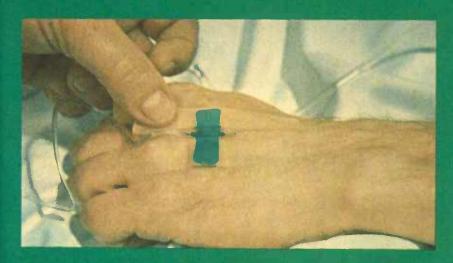
She said it is time the nursing profession changed its negative and protectionist approach to professional development in favor of a more cooperative attitude. "Modern medicare requires teamwork, experimentation, and cooperation. It also demands re-

### We've put a handle on VENIPUNCTURE...



Just hold the Butterfly Infusion Set by its "wings" and you're ready for venipuncture. The wings fold upward easily to serve as a needle holder. They give you a firm, sure grip: all the "handle" you need for accurate manipulation and early penetration of tissue and vein will

#### ...and an anchor on SECURITY



Start your next I.V. procedure with a Butterfly Infusion Set

Ultrasharp needle has a short-bevel point for easy entry . . . thinwall construction that allows for increased flow without increasing outside needle diameter. Slim, hub-less design and soft, flexible tubing for easier handling. There's a size for almost every infusion need. Ask your Abbott Representative to show you our entire collection.

Simply release the Butterfly wings after venipuncture. They fold back from their "uptight" position and lie flat against the patient's skin. Flat, but firm—a secure anchor surface. Just tape them down and the needle is completely immobilized.

Large-bore Butterfly-14 and 16 for surgery or hemodialysis

Medium-gauge Butterfly-19 and Butterfly-21 for general-purpose infusions

Special Butterfly-19, INT and Butterfly-21, INT with reseal cap for intermittent I.V. therapy

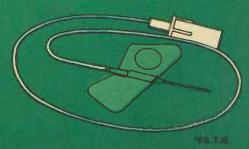
Small-gauge Butterfly-23 and Butterfly-25 for pediatric/geriatric use

Short-cannula Butterily Short-25 for scalp vein infusions

#### **BUTTERFLY** INFUSION SET



The Venipuncture Specialists—
Quality I.V. equipment to meet every need



# PERSON PERSON

## PROBLEM **PROBLEM**

### **NURSING IS ACIRCULAR PROFESSION**

A continuing chain of events demanding intelligent actions. Mosby texts evoke the right response.

#### **NUTRITION AND DIET THERAPY**

Utilizing a style and approach unsurpassed in any other text, this significantly revised new edition remains a leader in its field. It views nutritional science principles in the context of human need - in real life situations of daily living and stress. This new edition places increased emphasis on the role of nutrition in public health, in basic nursing specialties and in the clinical management of disease. New material has been added on hyperlipoproteinemia, nutrition during pregnancy and lactation, problems in control of food additives and lipoproteins. New tables of lipid disorders and current bibliographies aid further study. A teacher's guide, test manual, and information on application of the inquiry method of learning to nutrition education complete this effective classroom package.

By SUE RODWELL WILLIAMS, M.R.Ed., M.P.H. February, 1973. 2nd edition, 694 pages plus FM I-XVIII, 7" x 10", 117 illustrations including original drawings by GEORGE STRAUS. Price, \$11.05.

New 2nd Edition!

Williams

#### NUTRITION AND DIET THERAPY

A Learning Guide for Students

Specifically designed as a companion for the text, this new revision provides a basis for objective reasoning and application of knowledge. Organized in three major sections, its broad coverage includes: suggestions and techniques for study and problem-solving; a study guide for normal nutrition based on a stimulating questions approach; and applications of nutrition. Actual clinical case studies representing a wide range of patient, family, community and world nutritional problems provoke thinking about solutions to specific problems.

By SUE RODWELL WILLIAMS, M.R.Ed., M.P.H. February, 1973. 2nd edition, 136 pages plus FM I-X, 7½" x 10½". Price, \$5.25.

A New Book!

Williams

#### REVIEW OF NUTRITION AND DIET THERAPY

Mosby's Comprehensive Review Series

Organized in an effective question-and-answer format, this new book provides a thorough review of the entire nutritional spectrum, from basics to specifics. It emphasizes principles of nutrition as they relate to human health and applies this information on a practical level to community and clinical situations. Coverage of water and electrolytes, and digestion, absorption and metabolism is especially noteworthy. Other topics include: nutrition education; food habits; nutritional deficiency diseases; child and adult health problems; and more.

By SUE RODWELL WILLIAMS, M.R.Ed., M.P.H. February, 1973. 293 pages plus FM I-X,  $7'' \times 10''$ , 40 illustrations. Price, \$8.70.

#### INFECTION: PREVENTION AND CONTROL

This practical handbook backgrounds students in basic microbiology and epidemiology and presents commonsense policies and procedures for the development and maintenance of a complete infection control program. Emphasizing the nurse's supervisory role in infection control, the book discusses data collection and interpretation as a basis for program need assessment; emotional needs of the isolation patient; legal aspects of hospital associated infections: staff education: and more.

By ELAINE C. DUBAY, R.N., B.S.; and REBA D. GRUBB, Medical Writer. August, 1973. 160 pages plus FM I-XVI,  $6^{\prime\prime}$  x  $9^{\prime\prime}$ , 40 illustrations. Price, \$5.15.

A New Book!

A New Book!

McInnes

#### CONTROLLING THE SPREAD OF INFECTION

A Programmed Presentation

Requiring no prior knowledge of microbiology, this new programmed manual presents basic information on sources of infection; the interrelationship of microorganisms and the human host; the modes of transmission and portals of entry; and the variables that allow microorganisms to cause disease. Sound scientific principles of asepsis are set forward and correlated with specific technical nursing skills.

By BETTY McINNES, R.N., B.Sc.N., M.Sc.(Ed.) July, 1973. 112 pages plus FM I-XII, 7" x 10". Price, \$4.75.

A New Book!

Berni-Fordyce

#### **BEHAVIOR MODIFICATION** AND THE NURSING PROCESS

This new book helps students link learning theory and conditioning principles to the modification of deviant or disordered patient behavior. Discussions range from behavior analysis through reinforcement, with specific means to achieve behavior modification detailed. Other discussions consider systems management, ethical issues and future trends. Chapters are programmed to aid steady development; progress charts illustrate each case history.

By ROSEMARIAN BERNI, R.N., B.S.; and WILBERT E. FORDYCE, B.S., M.S., Ph.D. June, 1973. 136 pages plus FM I-XII, 5½" x 8½". Price, \$4.15.

A New Book!

Douglass

#### REVIEW OF TEAM NURSING

Mosby's Comprehensive Review Series

Help students gain the knowledge they will need to be nurse leaders with this new text. It carefully reviews team nursing and nursing's historical background, emphasizing the emergence of nurse leaders. Some of the many current topics examined are: processes involved in delegation of authority; group dynamics and communication; nurse characteristics; climates which influence behavior; and the theoretical basis for the study of nursing action.

By LAURA MAE DOUGLASS, R.N., B.A., M.S. August, 1973. 132 pages pius FM I-X, 5½" x 8½". Price, \$5,20.

#### INTRAVENOUS MEDICATIONS

A Handbook for Nurses and Other Allied Health Personnel

Until the writing of this handbook, pertinent information concerning intravenous medications was buried or lost in a maze of pages and fine print. This concise manual provides ready access to vital information on dosages, therapeutic actions, indications, contraindications, and sensitivity reactions. Cross indexed for generic and proprietary names, it puts specific STAT information at the student's fingertips.

By BETTY L. GAHART, R.N. May, 1973. 176 pages plus FM I-XII, 6" x 9". Price, \$5.00.

A New Book!

Gruendemann et al

#### THE SURGICAL PATIENT

Behavioral Concepts for the Operating Room Nurse

Presenting behavioral concepts and nursing principles that can apply to a variety of surgical patients and surgical situations, this unique new text helps students gain the background for making critical, independent decisions. A special method of classifying surgeries provides a clear understanding of both the surgery and the patient.

By BARBARA J. GRUENDEMANN, R.N., B.S., M.S.; SHIRLEY B. CASTERTON, R.N., B.S.; SANDRA C. HESTERLY, R.N., A.A.; BARBARA B. MINCKLEY, R.N., B.S., M.S., D.N.Sc.; and MARY G. SHETLER, R.N., B.S.N. April, 1973. 152 pages plus FM I-XII, 7" x 10", 64 illustrations. Price, \$5.80.



# The least you can do for hospitalized diabetics

It's not that you should do more. It's just that KETO-DIASTIX\* Reagent Strips require the least amount of effort in testing for glucose and ketones in urine. Simply dip into urine and get a semiguantitative reading for glucose and ketones in 30 seconds. What could be easier and less troublesome for you and the patient? Useful all around the hospital. On wards, at the bedside, in patient teaching centers, and in the O.P.D. Also, a good test to recommend for the patient to use at home after discharge. Obtain full details on KETO-DIASTIX by calling your Ames Systems Specialist or by writing to the address below. It's the least work you can do in diabetic urine testing.

#### **Keto-Diastix**

Ames Company



Division Miles Laboratories, Ltd. 77 Belfield Road, Rexdale, Ontario



#### news

orientation in the direction of the patient and the community."

Dr. Mussallem called on professional associations to provide more face-to-face dialogue so the best use can be made of existing resources, facilities, and personnel to improve health care systems. In the past, she said, the nursing profession was forced to concentrate on establishing its independence, sometimes to the detriment of relationships with other members of the health care team.

"Surely we can safely assume that our professional status is now secure. A profession... confident of its stature does not need to worry about its status," Dr. Mussallem added.

Noting that the days of the pleasant doctor-patient-nurse triangle have disappeared forever, the speaker said liaison between adjacent professions and occupations is now necessary if the public is to receive adequate health care.

Dr. Mussallem observed that other ways in which professional associations can increase their contemporary usefulness include seeking representation on planning bodies, and encouraging formal cooperation between various organizations and between professional associations and government agencies.

The associations that are still around in the 1980s "will be the ones whose structure and programs have been modified, after careful study of the direction in which the profession is headed, to keep up with the accelerated pace of change," predicted the CNA executive director.

N.S. Government Appoints Nurse To Health Services Commission

Halifax, N.S.—Last September, Nova Scotia's minister of public health appointed Muriel E. Small, RN, to the new Health Services Commission. Ms. Small was a nominee of the Registered Nurses' Association of Nova Scotia (see "names," page 36).

Health Minister Scott MacNutt said

Health Minister Scott MacNutt said that representation from the nurses' association would be of considerable benefit to the administration of the health system in Nova Scotia.

The Health Services Commission was created under new legistation, the Health Services and Insurance Act, which came into effect September 1, 1973. This Act combines the functions of the former Hospital Insurance Commission and the Medical Care Insurance Commission in Nova Scotia.

Chairman of the Health Services Commission is G.R. Matheson, Q.C., Halifax.

U.S. Senator Responds To ANA During Watergate Hearings

Washington, D.C.—The subject of nurses' ethics was raised at Watergate hearings last July, thanks to testimony given by John Ehrlichman and a correction announced by Senator Samuel Ervin a few days later, following protests from the American Nurses' Association.

In testimony given before the Senate Select Committee on Presidential Campaign Activities July 24 and 25, Mr. Ehrlichman implied it would be possible to obtain confidential information about a patient from a nurse, and therefore there was no need to burglarize a physician's files.

ANA, which received numerous letters from individual members and from state nurses' associations protesting Mr. Ehrlichman's testimony, sent both a memo and a telegram to committee chairman Ervin. The memo, sent by ANA's government relations division in Washington, said: "Our office continues to get calls from nurses who feel that patients will necessarily be concerned about their right to privacy after hearing Mr. Ehrlichman's comments earlier this week . . . ."

The memo followed a telegram sent by ANA to Senator Ervin, asking him to "advise members of his committee and others that the nursing profession has a Code of Ethics that requires the nurse to safeguard the individual's right to privacy."

Senator Ervin responded at the start of the Watergate hearings a few days later by announcing that ANA had a Code of Ethics, which requires nurses to protect a patient's right to privacy.

In her editorial in the September 1973 issue of the American Journal of Nursing, editor Thelma Schorr wrote: "We were aghast at John Ehrlichman's off-hand slander of nurses during his testimony before the Senate committee investigating the Watergate scandals. Discussing the burglary of Daniel Ellsberg's psychiatrist's office, the former presidential assistant announced to the world that confidential information about a patient 'is obtainable through nurses, through nurses' aides, through all kinds of sources . . . 'If anyone believed him and loses faith in the integrity of his nurse as a result, that could add injury to the insult.'

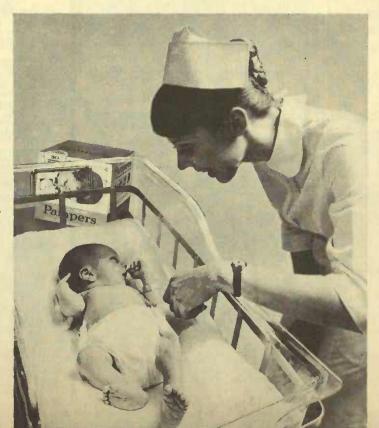
In conclusion, Ms. Schorr gave Mr. Ehrlichman the following advice: "Nurses live by an ethical code, Mr. Ehrlichman, that government officials would do well to emulate."

NOVEMBER 1973

# Pampers Pampers oives uboth abreak

#### Keeps him drier

Instead of holding moisture, Pampers hydrophobic top sheet allows it to pass through and get "trapped" in the absorbent wadding underneath. The inner sheet stays drier, and baby's bottom stays drier than it would in cloth diapers.



### Saves you time

Pampers construction helps prevent moisture from soaking through and soiling linens. As a result of this superior containment, shirts, sheets, blankets and bed pads don't have to be changed as often as they would with conventional cloth diapers. And when less time is spent changing linens, those who take care of babies have more time to spend on other tasks.

PROCTER & GAMBLE

MRS. R. F. JOHNSON SUPERVISOR CHARLENE HAYNES MRS. HOLBRUUN ANN COHN, L.P.N.

#### IT'S EASY TO ORDER REEVES NAME PINS FOR YOURSELF OR FRIENDS!

Choose style you want, shown left. Print name (and 2nd line if desired) on dotted lines below. Check other info in boxes on chart, clip this section and attach to coupon

bottom left. Attach extra sheet for additional pins. NDTE SAVINGS ON 2 IDENTICAL PINS... more convenient, spare in case of loss.

LETTERING:\_\_\_ 2nd LINE: BACKGROUNG COLOR (Plastic) PRICES\* RESCRIPTION ☐ Black ☐ Dk. Blue ☐ White ALL METAL ... rich, trim and tailored. Lightweight, smooth edges, rounded corners. Duotone Polisher Satin ☐ 1 Pin 1.98 ☐ 1 Pin 2.58 Does ☐ Gold 169 2 Pins 3.25 2 Pins 3.85 □ 5ilver apply Black
Dk. Blu PLASTIC LAMINATE...slimmer, broader; engraved thru surface to contrasting core color. Beveled border matches lettering. ☐ White Does ☐ 1 Pin .95 1 Pin 1.45 559 not not apply 2 Pins 1.65 2 Pins 2.30 White WETAL FRAMED ... Class □ Black
□ Dk. Blue sign; snow-white plastic with ooth, polished beveled frame frame MOLOEO PLASTIC...Simple, smi economical, Will never discolor. 1 Pin .95 1 Pin 1.45 White 510 nomical. Will never discolor, both rounded corners and edge

\*Please add 25¢ per order for 3 pins or less.

QUANTITY DISCOUNTS: 10-24 pins, deduct 10%; 25-99 pins, 15%; 100 or more pins, 20%



SCOPE SACK neatly carries and protects Nursescope or any scope. Double-thick frosted flexible plastic, white vinyl binding. 4½" x 9½". Your own initials help prevent loss. No. 223 Sack. . . 1.00 ea. Your initials gold-stamped, add 50, per sack.

#### NURSES PERSONALIZED ANEROID SPHYG.

ANCROID STITUS.

A superb instrument especially designed for nurses! Imported from precision craftsmen in W. Germany. Easy-to-attach Veldero cutf, lightweight, compact, fits into soft sim. leather zippered case 2½° x² 4′ x 7′ n°. Oil calibrated to 320 mm., 10-year accuracy guaranteed to 1.3 mm. Serviced by Reeves it ever required. Your initials engraved on manometer and gold stamped on case FREE, for permanent identification and distinction. A wise investment for a lifetime of dependable service!

No. 106 5bytes. . . 32.95 ea. No. 106 Sphyg. . . . 32.95 ea.



#### CAP ACCESSORIES

CAP TOTE keeps your caps crisp and clean while stored or carried. Flexible clear plastic, white trim, zipper, carrying strap, hang loop. Stores flet. Also for wiglets, curlers, etc. 8½" dia., 6" high. No. 333 Tote. 2.65 ea., 6 or more . . 2.35 ea. Your initials gold-stamped, add 50x per Tote.



WHITE CAP CLIPS Holds caps firmly in place! Hard-to-find white bobbie pins, enamel on fine spring steel. Eight 2" and eight 3" clips included in plastic snap box. No. 529 Clips . . 3 boxes for 1.95, 6 for 3.25, 12 for 49¢ ea.

(NAI)

#### MOLDED CAP TACS

Replace cap band instantly. Tiny plastic fac, dainty caduceus. Choose Black, Blue, White or Crystal with Gold Caduceus; or all Black (plain). The neeter way to lasten bands. No. 200 Set of 6 Tacs . . . 1.25 per set. 12 or more sets 1.00 per set





METAL CAP TACS Pair of dainty jewelry-quality Tacs with grippers, holds cap bands securely. Sculptured metal, gold finish, approx. 3," wide. Choose RN, LPN, LVN, RN Caduceus or Plain Caduceus. Gift boxed. No. CT-1 (Specify Initials), No. CT-2 (Plain Cad.) or No. CT-3 (RN Cad.) . . . 2.95 pr.

SELF-IA CAF DAILD BISCREVINE.

band material. Self-adhesive, presses on, pults off; no sewing or pinning. Reusable several times. Each band 20" long, pre-cut to popular widths: ¼" (12 per plastic box) ½".

(8 per box) ¾" (6 per box) ¾" (6 per box) ½" (8 per box) ½".

Specify width under IEEM column on coupon. No. 6343 Band. . . 1.75 per box



	TO: REEVES	COMPANY, Box	C , At	tlebor	Mass	02703	
Ü	DROER NO.	ITEM	COLOR	SIZE	QUANT.	PRICE	
H							
8				_ =			
i				-			
	Use extra sheet for additional items or orders.						

(Good idea . . . for distinctive identification)

TO ORDER NAME PINS, fill out all information in box top right, clip out and attach to this coupon.

1 enclos	e 5			. (Mass. reside	ents and 376	5. 1,
	Sorry,	no	COD's or	billing terms	available	
Send to	,,					

MEDI-CARD SET Handiest reference ever! 6 smooth plastic cards (3½" x 5½") crammed with information, including Equivalencies of Apothecary to Metric to Household Meas, Temp. °C to 'F, Prescrip. Abbr., Urinalysis, Body Chem., Blood Chem., Liver Fests, Bone Marrow, Disease Incub. Periods, Adult Wgts., Child's Dosages, etc. All in white vinyl holder with gold stamped caduceus. No. 289 Card Set . . . . 1.50 ea. 6 or more 1.10 ea. Your initials gold-stamped on holder, add 50¢ per set.



No. 25-72 Forceps . . . 2.75 ea. 6 or more 2.50 ea. Your Initials engraved, add 50¢ per forceps.



#### Free Initials and Scope Sack with your own



diaphragm stethoscope . . . a fine precision instrument, with high sensitivity for blood pressures, apical pulse rate. Only 2 ozs., fits in pocket, with gray vinyl anti-collapse tubing, non-chilling epoxy diaphragm. 28" overepoxy diaphragm. 20 over-all. Non-rotating angled ear tubes and chest piece beau-tifully styled in choice of 5 jewel-like colors: Goldtone, Silvertone, Blue, Green, Pink.\*

FREE INITIALS AND SACK! Your initials engraved FREE on chest piece; lend individ-ual distinction and help preual distinction and herp pre-vent loss. Also FREE SCOPE SACK included, worth \$1. as described above right. (Free sacks not personalized; add 50¢ if initials desired.) Ideal for group gifts! Note big sav-ings on quantity orders (left).

No. 216 Nursescope.

13.80 ea. ppd.
6-11...12.80 ea. 12 or more...11.80 ea.
Group Discounts include free Initials and Sack!

"IMPORTANT NEW FEATURE: New "Medallion" styling includes tubing in colors to match metal parts. If desired, please add \$1. ea. to all prices above, and add "M" to Order No. (No. 216M) on coupon.

Duty free

COMPLETE SATISFACTION GUARANTEED! All pric

SCISSORS Precision-made imported forged steel, Professional quality. Guaranteed 2 years



31/2" LISTER MINI-SCISSORS Tiny, handy, slip into uniform pocket or purse. Choose jewelers Gold or gleaming Chrome plate finish on coupon No. 3500 Mini-Scissors . . . 2.75 ea.

41/2" or 51/2" LISTER SCISSORS As above, but larger for bigger jobs. Chrome finish only, No. 4500 (4½") or No. 5500 (5½") Scissors . . . 2.75

51/2" OPERATING SCISSORS

Stainless steel, with sharp/blunt points. Beautifully polished finish

No. 705 OR Scissors . . . 2.75 ea.

All scissors above: 1 doz. or more (any style) . . . . Your initials engraved, add 50c per scissors.

CLAYTON DUAL STETHOSCOPE Light weight imported dual scope; highest sensitivity for pulse rate. Chromed head tubes and chest piece vi 1½" bell and 1½" diaphragm, grey anti-collapse tubing, 40.2, 29" long. Extra ear plugs and diaphragm included. Two initials engraved free. Duty free

No. 413 Dual Steth . . . . . . . . 17.95 ea. JEWELRY NURSES CHARMS

Finest sculptured Fisher charms,
Sterling or Gold Filled (specify under COLOR on coupon)
For bracelet or pendant chain. Add to your collection! No. 263 Caduceus; No. 164 Cap; No. 68 Grad, Hat; No. B. Band. Scissors . . 3.49 ea.



14K PIERCED EARRINGS

Dainty, detailed 14K Gold styles, for on or off duty wear. Shown actual size. Beautifully gift boxed.

fully gift boxed.

Birthstone Colors (specify on coupon): JAN
Garnet, FEB Amethyst, MAR Aqua, APR Crystal, MAY Emerald, JUNE Alexandrie, JULY
Ruby, AUB Peridot, SEPT Sapphire, DCT
Rose Zircon, NOV Topaz, DEC Blue Zircon.

No. 13/297 Caduceus; No. 13/276 Cross; No. 1/010 Ben. Cultured Pearl; No. 6/247 Birthstone \$ 5.95 per pair.

PIN GUARD Sculptured caduceus, chained to your professional letters, each with pinback/safety catch. Dr replace either with class pin for safety Gold finish, gift boxed. Choose RN. LPN or LVN. No. 3420 Pin Guard . . . . 2.95 ea.





(I)

CDA

ENAMELED PINS Beautifully sculptured status insignia, 2-color keyed, hard-fired enamel on gold plate. Oime-sized, pin-back. Specify RN, LPN, PN, LVN, NÅ, or No. 205 Enam. Pin 1.95 ea., 12 or more 1.50 ea.

POCKET SAVERS Prevent stains and wear smooth, pliable pure white vinyl. Ideal low-cost group gifts or favors.

No. 210 E (right), two compartments with flap, gold stamped caduceus . . . 6 for 1.50, 25 or more 20¢ ea.

No. 791 Dett) Deluxe Saver, 3 compt.



Handiest for busy nurses Includes white Deluxe Pocket Saver, with 5½" Lister Scissors (both shown above), Tri-Color ballpoint pen, plus handsome little pen light ... all silver finished. Change compartment, key chain

No. 291 Pal Kit . . . . . . 4.95 ea 3 Initials engraved on shears, add 50, per kit.

BZZZ MEMO-TIMER Time hot packs, heat lamps, park meters. Remember to check vital signs give medication, etc. Lightweight, compact (1½" die.), sets to buzz 5 to 60 min. Key ring. Swiss made.

No. M-22 Timer . . . . . . 4.95 ea.



3 or more 3.95 ea.; 6 or more 3.50 ea.

**EXAMINING PENLIGHT** CDM White barrel with caduceus imprint, aluminum band and clip. 5" long, U.S. made, batteries included (replacement batteries available any store). Your own light, gift boxed.

No. 007 Penlight . . . 3.58 es. Your Initials engraved, add 50¢ per light.

### Uniform Fashions Reeves



SAFARI

Check this safari belted pant suit. The belt can be worn in front to hide slightly gathered waist, or as a back belt. New "No-Trip" Cuff to avoid hazard of catching heel; easy to alter, too. 100% Polyester Warp Knit "Carousel"; 34 Sleeves.

STYLE No. 4635
SIZES: 4-20

\$1ZES: 4-20 29.95 (set) ppd. \$TYLE No. 7635 \$1ZES: 14½-24½ 31.95 (set) ppd.

#### GIBSON GIRL

Youthful high-rise waist, soft shirred skirt, pleated blouse. Inner surgical pocket. Mini length.

STYLE No. 4624 100% Polyester Warp Knit; 34 Sleeves.

SIZES: 3/4-15/16 18.95 ppd.

STYLE No. 4824 60% Dacron Polyester, 40% Nylon Cord Jersey.

Short Sleeves.

SIZES: 3/4 – 15/16

15.95 ppd.





Chinese square mandarin, with milti-tuck front yoke, smartly accented with buttons on front flange, back zipper. A different style for today's nurse. 34 Sleeves. 80% Dacron Polyester, 20% Cotton Super Faille.

STYLE No. 4726 SIZES: 8-20 17.95 ppd. STYLE No. 5726 SIZES: 4-14 Petite 17.95 ppd.



Unique smock style in a professional uniform . . . tor soft feminine appeal.

Large generous patch pockets and inner surgical pocket. Short Sleeves. 100% Dacron Polyester Double Knit "Crystalon". A little girl look at the top of fashion.

STYLE No. 4632 SIZES: 3/4 — 15/16 21.95 ppd.



#### Please Use Coupon Opposite Page

#### dates

#### November 17, 1973

Seminar on "Recognizing Stress: Going Through Stress: The Answer to Stress' sponsored by Nurses' Christian Fellowship, Toronto, to be held at the Addiction Research Foundation, 33 Russell St., Toronto. Fee: graduates — \$6.00; students — \$4.00. For further information, write to: Ms. Judy Van Gent, 40 Reidmont Ave., Agincourt, Ontario. M1S 1B4.

#### November 21-23, 1973

Saskatchewan Hospital Association, annual meeting, Saskatoon, Saskatchewan. For further information, write to the Saskatchewan Hospital Association, 236 College Avenue, Regina, Saskatchewan.

#### **December 1, 1973**

15th Conference on the Medical Aspects of Sports, sponsored by the American Medical Association, Royal Inn, Anaheim, California. Conference theme: "Health Care for the Athlete: A Community Concern." For further information, write to: Committee on the Medical Aspects of Sports, 535 North Dearborn Street, Chicago, Illinois 60610, U.S.A.

#### February 18-22, 1974

Occupational health nursing program for registered nurses employed in the field of occupational health nursing. Fee: \$95. For further information, write to: Continuing Education Program for Nurses, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ontario.

#### April 29-30, 1974

Ambulatory Pediatric Association, 14th annual meeting, Sheraton-Park Hotel, Washington, D.C. Abstracts are invited to be considered for presentation at the scientific sessions. For further information, write to: E.S. Hillman, M.D., Montreal Children's Hospital, 2300 Tupper St., Montreal 108, Quebec.

#### May 2-4, 1974

Vancouver General Hospital 75th anniversary, gala celebration and alumni banquet, Regency Hyatt Hotel, Vancouver, B.C. For further information.

write to: Executive Secretary, VGH Alumni Association, 2851 Heather St., Vancouver 9, B.C.

#### May 5-10, 1974

Third Canadian Operating Room Nurses' convention, The Queen Elizabeth Hotel, Montreal, Quebec. For additional information, write to: Ms. Peggy Iton, c/o Jewish General Hospital, 3755 Cote St. Catherine Road, Montreal 249, Quebec.

#### May 31-June 1, 1974

Association for the Care of Children in Hospitals, 9th annual conference, Sheraton-Chicago Hotel, Chicago, Illinois. Children's Memorial Hospital of Chicago is the sponsoring institution. Conference theme: "Who puts the pieces together?" A pre-conference seminar on play therapy will take place on May 29, 1974. For registration and program information, write to: Myrtha Sice, Recreational Therapy Dept., Children's Memorial Hospital, 2300 Children's Plaza, Chicago, Illinois 60614, U.S.A.

#### June 16-21, 1974

Canadian Nurses' Association annual meeting and convention, to be held in the Manitoba Centennial Centre Concert Hall, Winnipeg, Manitoba.



#### June 16-22, 1974

World Confederation for Physical Therapy, seventh international congress, The Queen Elizabeth Hotel, Montreal, Quebec. Theme: "Expanding Horizons of Physical Therapy." For further information, write to: Congress W.C.P.T. Registration, P.O. Box 6374, Station A, Toronto, Ontario.

#### June 17-20, 1974

Canadian Public Health Association, 65th annual meeting, Arts and Culture Centre, St. John's Newfoundland. Theme: "Patterns of Health Delivery — Rural and Urban." For further information, write to: CPHA, 1255 Yonge Street, Toronto, Ontario M4T 1W6.

### Here is a new, fast and sterile way to prepare Xylocaine infusions

for life threatening arrhythmias



### **Xylocaine®**

(Lidocaine Hydrochloride Injection, Astra Std.)

ne Gran

- The special 5 ml transfer syringe contains 200 mg/ml Xylocaine and can be added to infusion set-ups without removing solution from infusion flask or bag
- Cuts preparation time in half
- Easy and convenient to use
- Adds another link to the sterility chain
- Disposable
- Clearly labeled for positive safeguard against error

ASTRA Pharmaceutical Division. Mississauga, Ontario



# The nurse in a student physician's "practice"

A controlled clinical environment, volunteer patients, and a nurse-administrator provide student physicians with a unique and worthwhile learning experience in their medical studies. This educational project owes its sense of reality to the willing response and cooperation of volunteer "patients."

#### Barbara Valberg

The Clinical Learning Centre at Queen's University in Kingston opened its doors November 30, 1972, primarily for teaching clinical skills to beginning medical students. As its nurse-administrator, it was my responsibility to set up and organize the program and to recruit volunteer "patients."

The center was established for several reasons, among them the introduction of a revised clinical skills course in the medical school curriculum. Other factors were the closing of 100 beds in Kingston hospitals, and the expectation of an increased student enrollment.

The revised clinical skills course greatly increased the dependency of the medical school on the goodwill and cooperation of hospital patients. It became apparent that there was a need for a location where clinical skills could be acquired in a sheltered environment removed from the distractions of busy wards — a place where second-year medical students would not be dealing with seriously ill patients, nor interfering with the duties of a busy staff.

In an educational setting, students would feel more at ease, gain more confidence, and have time to develop better relationships with patients.

Our Project was designed to:

determine whether patients would be willing to come to a facility to take part in the education of student physicians, especially if that facility were removed entirely from the hospital itself.

Dindicate whether students working with ambulatory volunteer patients, could, in this type of environment, learn such clinical skills as history taking, physical examination, and record keeping.

provide "office practice" experience approximating the environment in which the majority of medical students would find themselves after graduating.

We leased the third floor of one of the nurses' residences of Kingston General Hospital. There were 18 rooms, which needed only minor alterations to transform them into a warmly decorated unit closely resembling a

family practice unit or outpatients' clinic. Every inch was used to accommodate the eight office-examining rooms, a conference room, an office-waiting room, a reading room for clinicians and students, and an office for me, the nurse-administrator.

Each office-examining room was equipped with a desk, three chairs, an examining table, and a set of instruments. Three of these rooms were fitted with one-way mirrors so instructors in adjacent "viewing" rooms could observe a student's performance. Sound equipment allowed the teacher to listen in on the student-patient interview.

#### Recruitment of "patients"

We recruited volunteer teachingpatients, mainly from the practices of physicians responsible for the clinical skills course; 40 patients volunteered on their own, after talking with other "patients" and students or after learning about the center in newspaper articles or on television.

Our patients were not paid for their time, except for one young man who was taught to assist in nine orthopedic sessions. He learned different gaits and how to simulate deformities, and became the model used to demonstrate an

Ms. Valberg is the nurse-administrator at the Clinical Learning Centre in Kingston. This Centre was established by Dr. A.M. Bryans, Director of the Health Sciences Office of Education, Queen's University, through a grant from the Ontario Department of Health.



Young prospective "patients" feel at ease in waiting room of the Clinical Learning Centre.

examination of the locomotor system.

I interviewed each potential volunteer, explaining there would be no diagnostic or treatment benefit to him but that there could be satisfaction in contributing to a worthwhile educational project. I stressed the importance for medical students to achieve good human relationships and to acquire practical skills. It was gratifying that so many people were not only willing to help, but glad of the opportunity to do so.

Using patient volunteers allowed me to select the person who best conformed to each student's level of ability. In this way, a student could progress from examining pleasant, cooperative patients with simple histories to those who were more difficult to communicate with, and whose histories were more complicated.

The class receiving training at the center was divided into nine groups of eight students each. Three physicianteachers were assigned to each group. The groups rotated through the center, and spent two hours to complete a

session.

Before each session, I contacted the patients needed, scheduled their appointments, and arranged transportation where necessary. We offered to pay transportation expenses.

#### "Patients" visit center

On arrival at the center, patients were escorted to the waiting room, where I introduced them to one another and offered tea or coffee. Besides enabling everyone to feel at ease, this short social period gave me an opportunity to obtain statistical data and to make certain each patient fully understood the procedure.

Occasionally student-patient introductions took place in the waiting room, but I found it more realistic to have the patient meet his "doctor" in the office-examining room. The student had already been supplied with a card inscribed with the patient's name, age, and reason for visit.

When the patient was female, the student left the room after taking the history and explaining that the nurse would assist her to prepare for the examination. Assisting in this case meant telling her how much to take off. A gown and sheet were supplied for each patient.

During the examination, I assisted where necessary (handing instruments, or draping the patient), and remained during the examination of chest and abdomen. If the patient needed further assistance, I remained through the entire session. I soon realized we needed more than one nurse, and I was fortunate in recruiting two nurses who volunteered to spend half a day per week with us.

The teachers, by means of the oneway mirrors and sound equipment, were able to observe and listen in on examinations while they were being conducted.

Although some were initially skeptical about the use of one-way mirrors, it has been our experience that student and "patient" alike preferred to have the teacher in the viewing room, rather than present in the examining room. Indeed, one mother informed me that

18 THE CANADIAN NURSE

it was distracting for her and embarrassing for her daughter, as the patient, to have the teacher coming into and going out of the examining room.

#### Assessment

After each session, I obtained assessments from the patient, the student, and the teacher. Students' comments were positive with few exceptions, and indicated that they were in favor of the system. They particularly appreciated: I. not imposing on a patient who had been examined repeatedly by interns and residents, but who had come to help them with their learning; 2. having a complete set of instruments at their disposal; and 3. the quiet environment, with no interruptions by routine nursing procedures or visitors.

One student remarked, "I heard heart sounds I never heard before." The realization that they were not imposing on sick patients made students feel free to spend adequate time on the visit.

During my interview with the patient after the session, I attempted to discover his feelings about the experience: Was it what he expected? if not, how was it different? Invariably the answers were, "It was better and more pleasant than I expected" or, "it was the most thorough examination I have ever had!"

I continued my interview by seeking his impressions of the student: Did he seem interested in you? Did he appear to be sincere? Did he call you by name? Did he look at you directly?

I asked about the student's manner, his grooming, and whether he made the patient feel at ease during the session: Did he explain what he was about to do? Did he reassure you if you were uneasy? Did you feel he was sure of himself? (The student who forgot to put the stethoscope into his ears was not!) Finally, I asked what the patient could suggest to improve the student's performance.

Patients answered all questions readily, after I assured them that their criticism would not discredit the student, but might actually be to his benefit; when informed of his mistakes, he would in all likelihood do a better job the next time.

I ended the interview by asking the patient if he would consider making a return visit. Many returned two or three times; one patient made seven visits.

The student obtained feedback from his patient either through his teacher or in a group discussion with patient, teacher, and himself. He was then able to see his strengths and weaknesses. One student didn't realize his own strength. His patient commented after the examination, "I should have been a 200 pound football player!"

On the whole, teachers were happy with the project, and considered the center an ideal environment for beginning students to learn clinical skills. They appreciated the reaction of the patient which, added to their own observations, helped them to make a more complete assessment of a student's performance.

Facilities for videotaping the clinical examination were available to the student if he wished to monitor his performance in addition to receiving feedback from his teacher and patient. This equipment was also used to prepare video tapes of student-patient interviews for teaching other students.

#### Simulated patients

Occasionally, we used simulated patients in the center. Students from the faculty of education and the

Queen's University drama course were coached to act as patients afflicted with various illnesses. Some played their parts so well that the students who examined them almost believed they were dealing with genuine patients.

The simulators welcomed the opportunity to test their acting ability, and were pleased to be involved in a pilot educational program. One drama student was able to depict the symptoms of several ailments, and used the experience as a dramatic exercise. She developed a new character for each visit.

When term ended, four months after the center opened, more than 100 students had benefited, and 353 visits had been provided for the program. The register showed 118 children who came with their mothers, and 148 adults. The atmosphere at the center on the days the children attended was like a nursery school. We provided toys and play equipment, juice, and cookies to make the experience for the children as pleasant as possible.

In March, the pediatric oral examinations of the Royal College of Phy-

Student nurse greets a young patient in the waiting room of the Clinical Learning Centre, Kingston, Ontario.



sicians and Surgeons of Canada were held in the center, using patients from the register. The candidates were well satisfied with the environment. They particularly appreciated the quiet atmosphere and the fact that mothers were present to give the history and to assist with the examination of young patients.

#### Conclusion

During my six months, active association with the Queen's University Clinical Learning Centre, I became acutely aware that, until the students began attending the sessions, their contact with nurses, except for head nurses on the wards, had been rare.

Early in the program, I sensed that students were unaware of the nurses' role during physical examinations, and that my presence made them feel uncomfortable. They seemed to consider me an intruder in the relationship they were trying to develop with their patients, and I believe many were under the impression that I was a spy!

However, as time went on, they came to realize that a nurse in the room could be a help rather than a hindrance; therefore, I am led to conclude that a clinical learning center might prove a suitable environment for coordinating some aspects of both medical and nursing education.

My own experience as nurse-administrator was an interesting challenge; I enjoyed my contacts with the students, and it was gratifying to find that so many people are willing to participate on a voluntary basis in the education of medical students. The splendid cooperation of the "patients" involved, proved this, the first hypothesis.

The second hypothesis, that students can learn as well at the center as they do on the wards, is being tested; but assessments collected to date from patients, students, and teachers certainly indicate that this second theory will also be proved correct.



Student physicians soon realize that a nurse in the examining room can be of help.



Student nurse practices interviewing and history-taking skills.

### Student nurses share in clinical learning

A program designed for student physicians has been adapted to include nursing students, who also need to learn clinical skills at the level of primary

#### Dawn Corbett

The Clinical Learning Centre at Queen's University affords student nurses primary health care experience in a setting specifically set up for student learning.

Our pilot program was devised to give a small number of second-year students from the Kingston General Hospital school of nursing a brief clinical experience in the center. Its objectives were to allow student nurses to. I. practice communication and interviewing skills in a simulated doctor's office; 2. assist the student physician with a complete physical examination of a patient; and 3. work with the student physicians to develop their respective roles in history taking and physical examination of patients.

The five volunteer student nurses who participated each had three twohour sessions at the Clinical Learning Centre. The first session took the form of a classroom review and application of interviewing skills. This gave the students an opportunity to role play responses to situations particular to an ambulatory clinic setting. The students also discussed and practiced methods of obtaining information from patients in an indirect and non-threatening manner. A tour and orientation to the center was given at this time.

In the next two sessions, each student nurse worked with a student physician. First, she greeted the patient in the waiting room and, after putting him at ease, attempted to make a primary assessment of the reason for his visit to the doctor. She then conducted him to the "doctor's office" and introduced him to the student physician.

As she sat in on the history taking, she made her own observations on the patient. During the examination she

draped and positioned the patient, handed equipment to the student physician, explained procedures, and reassured the patient.

On completion of the examination, the student nurse helped the patient get ready to go home and, at the same time, sought information concerning his feelings about the experience. Positive and negative comments were later recorded on a specially designed form.

The patient was escorted back to the waiting room, offered refreshments, and had arrangements made for his transportation home. On a few occasions, the student nurses were able to do some incidental health teaching.

#### **Evaluation**

In general, the student nurses found this a good learning experience. They commented favorably on the pleasant, leisurely atmosphere of the center and welcomed the opportunity to chat with patients in the waiting room. They gained satisfaction in following a patient from the beginning to the end of his visit and felt they got to know the patient quite well in that brief time.

One student stated she had never "really listened" to a history being taken before, and another commented, "It is a nice feeling to know that they (student physicians) are just learning too."

The students considered they had met their first two objectives, but had fallen short of meeting their third. Some student physicians did not seem to be prepared for the student nurses' pres-

Ms. Corbett is coordinator, Kingston General Hospital school of nursing, Kingston, Ontario.

ence and did not understand why they were there. There was little opportunity for the student nurses and physicians to discuss their learning experience, due to tightly scheduled timetables.

However, having nursing students and student physicians meet at some points in their education (other than socially!) appealed to the student nurses. They agreed that the traditional concept of physicians being "boss" and nurses being their "handmaidens" could be obliterated by having the two groups of students learn together. Graduate physicians and nurses could better understand one another's role by having a chance as undergraduates to communicate with one another about their programs and clinical experiences. This, they believed, would result in more efficient health teaching and higher quality patient care.

#### Conclusion

A controlled learning environment, such as the Clinical Learning Centre, appears to provide a worthwhile "first contact" clinical learning experience for student nurses and student physicians alike.

Most significant for Kingston's medical and diploma nursing education programs, which have until now run a parallel course, is that they have met in a cooperative effort at the Clinical Learning Centre.

#### **Bibliography**

Tanner, Libby and Sontary, Ethel J. Interprofessional student health teams. Nurs. Outlook 20:2:111-5, Feb. 1972.

Resenaur, Janet A. and Fuller, Dorothy J. Teaching strategies for interdisciplinary education, Nurs. Outlook 21:3: 159-62, Mar. 1973.

### smoking

#### **NOW and THEN**

Throughout the centuries, the smoking of tobacco has been many things to many people: a ritual of peace, a "magickal herbe," a sign of sophistication, a symbol of emancipation, and a "friend" who is always there and always comforting. In reality, however, smoking is a harmful habit and a "damned nuisance."

Nancy Garrett, R.N., M.P.H.

A nurse recently said to me, with great feeling, "There is nothing worse than a converted anything!" This was her comment after hearing I had smoked for 20 years — often two packs of eigarettes a day and sometimes more — before giving up the habit. I had expressed my surprise at finding nurses smoking at a meeting to which they had come to advise on education and health care for respiratory diseases.

I've noticed that whenever I mention the subject of smoking, both smokers and nonsmokers begin to shift uncomfortably, look embarrassed, and edge away. Nurse friends have accused me of moralizing. Leaders in the profession have asked, "Is this *really* a priority issue for nursing?"

This situation illustrates the problem we face in trying to combat smoking. But why is there such a reluctance to discuss such a serious health hazard?

Clearly, smoking is not a rational activity and does not respond to the normal weaponry traditionally used in preventive health care. We have no vaccinations to prevent it and no antibiotics to get rid of it. By mentioning the subjects, we "puritans" are seen to be censuring smokers as racy types of dubious morals. We break the hallowed

rules governing human rights — the right of smokers to pollute the air of the majority.

#### Smoking came "with parcel"

When the New World was discovered, smoking eame with the parcel. Unfortunately, the Indian ritual restricting its use — to signify peace after war — was not adopted. The French settlers learned to smoke and, despite the initial opposition of the French government, began to grow their own tobacco.

Tobacco was introduced into Europe because it was alleged to have great medicinal properties. Believing that tobacco conferred immunity during the Great Plague of 1665, even non-smokers chewed or smoked to protect themselves. Mothers furnished school

Ms. Garrett is a Research Officer with the Canadian Nurses' Association, Ottawa. This article is adapted from a paper she presented April 28, 1973, at the second refresher course in respiratory diseases in Toronto. The course was sponsored by the Registered Nurses' Association of Ontario, the York-Toronto TB & RD Association, and Ont. Thoracie Society.

boys with filled pipes and then school masters taught the children how to smoke.<sup>1</sup>

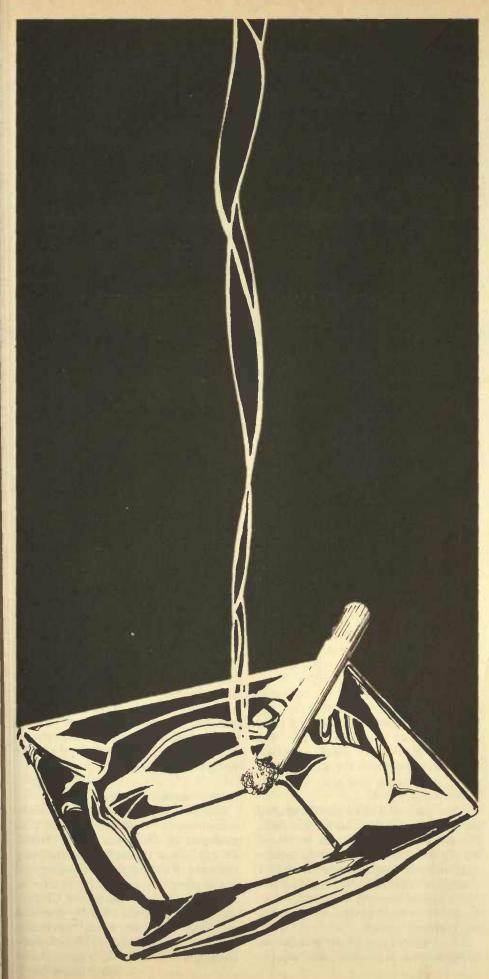
Tobacco was sold by apothecaries for the first 20 to 30 years of smoking's history. It became a multipurpose remedy. So, it was natural that "the chemist who was also a physician of a kind, should prescribe and sell the 'magickal herbe'."

Thanks to its publicist, Sir Walter Raleigh, pipe smoking became popular in England. Even Queen Elizabeth I tried it, but subsequent nausea precluded a second try. (She did not fail to see the revenue possibilities, however, and imposed a heavy tax when smoking took root.) Once started on any new practice, the Elizabethans took it up with zeal. By the time Elizabeth died in 1603, tobacco smoking had become a national habit.

The poor were determined to smoke, and adulterated the costly leaf with all manner of ingredients. Rather than buy a pipe, they could make one from a walnut shell, perforated to accommodate a straw through which they could "drinke" their pleasure. The wealthy equipped themselves and presented gifts of exquisitely carved tobacco boxes, pipe cleaners, scrapers,

NOVEMBER 1973

22 THE CANADIAN NURSE



silver pipes, and other paraphernalia to enhance the fashionable habit.

Equipment was not enough. The elite had to smoke with elegance. So taverns and wine houses saw the emergence of instructors "offering a full course in the art, 'with all the accompanying graces,' to the young bloods of the day."<sup>3</sup>

With the death of Elizabeth came the first prohibition of the drug. James I hated tobacco and condemned smoking as "loathsome to the eye, harmful to the brain, dangerous to the lungs," His deprecations and condemnations had no noticeable effect on tobacco sales, so he increased the tax about 40-fold, limited Virginian production to 100 pounds per year, and forbade tobacco growing in England, saying the growth of food would be jeopardized.

Prohibition was not effective, except to stimulate illicit trade. Finally, James gave up. He allowed London, and later Bristol, importing privileges, but retailers had to be licensed. Fashion eventually demanded (what initially began out of respect for the crown) that men receive permission to smoke after dinner; hence the well-known, after-dinner sanction, "Gentlemen you may smoke." This was the royal compromise, as men could not be persuaded or ordered to give it up.

Charles II continued restrictions on the import and sale of tobacco, and Cromwell decided that tobacco growth was a misuse of the land and had the crops trampled by troops. Smoking was a profanity to the Puritans. Charles II and other sovereigns realized they could not prevent smoking, so reaped the benefits of import duties and heavy taxes.

This period saw the beginning of widespread persecution of smokers. "In Russia they were tortured, sent to Siberia, had their property confiscated and their noses cut off." In Berne, smoking was ranked as sinful as adultery and was punished accordingly. The Pope excommunicated those taking tobacco or snuff into Roman churches.

Pipes and cigars popular

By the eighteenth century, smoking clubs became the rage. Paintings portrayed beautiful women, such as Mme Le Brun (Dunhill collection), gracefully smoking long-stemmed pipes. Indeed, it was not considered unusual for women to smoke pipes.

Pipes of all sizes, shapes, and materials tempted the fashionable and the

THE CANADIAN NURSE 23

witty alike. The French, to insult the Duke of Wellington who detested smoking, popularized a clay pipe with a figure of a Frenchman "cocking a snook" at him.8

Cigars gained popularity in the nineteenth century, to the general disgust of women in England. Queen Victoria's guests were forced to smoke up the chimney.<sup>9</sup> But some women took to the "brown roll," as evidenced by an 1877 wood cut showing a woman on a train, enjoying her rights to smoke a Havana cigar, seated beside her husband in the smoking car.<sup>10</sup>

Smoking rail carriages were introduced in 1846 in England, and men were so jealous of their new freedom that a cartoonist of the time portrayed a man complaining to the guard because a fellow traveler was not smoking.

Although the wives of Andrew Jackson and Zachary Taylor smoked pipes while in the White House, by the mid-1800s, women's image in America took on the romantic notion of womankind as fragile flowers. Pipes for women then went out of fashion, except in rural areas.

#### Cigarettes introduced

Cigarettes came on the European scene from South America via Spain, and were finally introduced into England by a Scotsman, after he saw the French, Turks, and Russians smoking them during the Crimean War.

In about 20 years, various brands, perfumed and plain, were available in colors to match ladies' dresses. One firm put out a pack with a carbon and glass mouthpiece as a filter.

Promotional activities begun then are still popular. Cigarette cards, initially meant to serve as package stiffeners, soon became a pictorial series of actresses. The moralists took note, protesting loudly against the use of cigarette cards that showed buxom beauties with "luscious legs."

By the end of the century, only the most daring woman would be seen

smoking, even in New York City. In some countries, women from the lowest castes still do not smoke and see North American women as the epitome of wickedness and degradation.

The flappers of the 1920s used cigarettes as symbols of emancipation, thereby glamorizing them. However, the concept of sinfulness in smoking has never quite disappeared. When we talk of Suzy, that sweet girl who teaches kindergarten at the local school, we do not, even today, anticipate that she will smoke.

#### Warnings about smoking

The moralists were not alone in their comments against smoking. The cautious voice of medicine often spoke over the centuries against smoking. As early as 1689, the Medical School of Paris officially sponsored the view that tobacco smoking shortened life.11 Tobacco was associated by various physicians with nervous paralysis, loss of intellectual capacity, impaired vision, mental illness, and the cause of moustaches on feminine lips. And, according to a Dr. Tidswell, in 1912, "the most common cause of female sterility is the abuse of tobacco by males . . . Those countries that use most tobacco have the largest number of stillbirths."12

We tend to be amused by these opinions, but on analysis we find they are not so far-fetched after all. The press has reported studies showing that smokers have more facial wrinkles, which may be worse for some women than moustaches because they are harder to get rid of.

There is evidence of some impaired judgment in drivers who smoke. Also, the lactate removal system is altered by cigarettes so that paralyzing cramps may be more common in smokers after strenuous exercise. A smoke-filled room makes the eyes sting and water. Certainly in some nurses' coffee rooms the visibility is poor.

Dr. Tidswell would be gratified to know that his colleagues today support

his observations, albeit with slightly different reasoning. In a small number of men, heavy smoking has been implicated as a contributing cause of infertility — hence their wives are "sterile." According to British statistics, women who smoke have a 30 percent higher chance of delivering a dead baby.

In 1859, one of the first reports linking smoking and disease was published in France. It was based on the observation of 68 patients with lip and mouth cancer. Sixty-six patients smoked clay pipes.

Despite this early documentation, little action was taken to prevent smoking, except by moralists.

Tobacco lobbyists have a long history of success, for good reason. According to one early estimate, the regular smoker will spend from \$7,000 to \$10,000 on cigarettes during his lifetime. This kind of incentive has led to bigger and better advertising that appeals especially to the young.

As Anne MacLennan pointed out in a recent press report, "Canadians have the dubious distinction of being just about the most persistent smokers in the world, according to the latest figures from the Tobacco Research Council here." Forty years ago, Canadians smoked 640 cigarettes each. By 1971 they were smoking five times as many—about 3,320 cigarettes each. Adding the roll-your-owns, the total reaches 3,750 cigarettes per person yearly, which means Canada is the world leader in cigarette smoking.

#### Nurses "smoke with zeal"

Nurses have been among the most conscientious smokers. Despite the evidence of five major U.S. Public Health Service reports of overwhelming evidence of the dangers of smoking and the increased general public awareness, as late as 1971, 27 percent of California nurses surveyed actually admitted to being uncertain about the health hazards of smoking. A 1970 U.S. Public Health Service survey, reaping 3,344

**NOVEMBER 1973** 



responses from nurses, found that 32 percent of smokers did not believe in their role as exemplars.

The only study of nurses' smoking habits in Canada was done in 1969 by Dr. A.J. Phillips of the National Cancer Institute of Canada.\* He compared smoking behavior of nurses and teachers to that of the general population. His study showed that fewer nurses smoked regularly (28.7 percent) than did Canadian women over 20 years of age in general (33.3 percent); but those nurses who smoked did it with zeal.

smoke more than 25 eigarettes per day. The 1970 U.S.P.H.S. study showed that although nurses give up smoking at a faster rate than women in the general population (21.5 percent as compared with 8.7 percent), we cannot ignore the fact that women not only have greater difficulty in quitting once they have begun smoking, but the relapse rate

nurses are women.

More men smoke than women, but

is greater than the male rate. Most

Only 20.7 percent of the smoking

nurses, as compared with 27.8 percent

of Canadian women, were smoking

less than 10 cigarettes a day. This means

that 31.7 percent of nurses are con-

sidered heavy smokers, that is, they

smoke over 20 eigarettes per day, while

only 4.3 percent of women in general

the proportion is not double. Yet male ex-smokers outnumber female ex-smokers two to one. According to Women and Smoking, by Brody and Engquist. 14 women get a bigger "kick" out of cigarettes than do men, apparently because they are more susceptible to the effects of nicotine. Several studies of male and female smokers show that nicotine has a much greater effect on the cardiovascular system of women than of men.

Between 1965 and 1970, the proportion of boys in the 15- to 19-year old age group who smoked remained about the same, 35 percent in 1965 and 35.7 percent in 1970; on the other hand, girls in the same age bracket increased by 6.2 percent, from 18.7 percent in 1965. to 24.9 percent in 1970. These kinds of statistics provoke a good deal of soul searching. What is causing women to take up smoking at an increasing rate at a younger age, when their potential risk is much greater?

One explanation is the need to look and act sophisticated. The eigarette has not been permitted to teenagers until recently. It is still a symbol of the independence and freedom for which women have fought for many years. For some, a cigarette becomes a friend who is always there and always comforting.

#### Know the facts

How can nurses hope to do anything to reduce the numbers of smokers and the effects of smoking? First, they need

to inform themselves.

An urbanite, smoking a pack of cigarettes or more per day, has an 11 percent higher cholesterol count, and "a 2.5 greater chance of having an 'abnormal' cardiogram than a nonsmoker."15 Over 10,000 Canadians died from respiratory disease in 1971, excluding the 5.786 fatalities of the lung cancer epidemic. 16 This exceeds the rate of traffic fatalities in Canadian men and is second only to mortality from heart attacks in males aged 45-64.17

The gap in the ratio between males

\* An article "Smoking habits of Canadian nurses and teachers," by Dr. Phillips. was published in the April 1969 issue of The Canadian Nurse.

and females dying from sudden heart attacks has narrowed. This increase in female deaths from sudden heart attacks has been attributed to increased smoking by women.<sup>18</sup>

Evidence of the injurious effect of smoke on nonsmokers, as well as on smokers, is increasing. Allergies, asthma, and upper respiratory infections in children have shown higher incidence where the environment has been infected by tar, nicotine, and volatile irritant gases in poorly ventilated rooms filled with smoke.

Cadmium was measured in a room 10' X 12' before and at intervals after a package of cigarettes had been smoked. 19 Even when only 10 percent of eadmium remained in the room, the level was still 10 times higher than before smoking. Cadmium is a respiratory poison.

Other studies have found that smokers' children are ill more frequently than nonsmokers' children. "Most of the difference between the two groups was found to be in the respiratory disease category."<sup>20</sup> Also, parents' smoking behavior appears to be a significant factor in influencing their children to smoke.

#### Nurses must set example

A concerted effort is needed by all nurses to set an example to each other and to the public. This means teaching everywhere. Literature, aids, posters, and funds are available from Health and Welfare Canada, for anyone interested in knowing the facts and in starting a program to help smokers "kick the habit."

More and more nonsmokers are demanding their rights to breathe air that is uncontaminated by eigarette smoke. Nurses can capitalize on this growing movement by promoting community interest in smoking withdrawal clinics. Help and information on how to conduct a clinic can be obtained from Seventh Day Adventist church members or from the tuberculosis and

respiratory disease association in the

Nurses can help to promote fitness and health or family education programs. A health concept (without the Canada-food-rules approach) can be incorporated from kindergarten, if children are given the opportunity to learn what lungs are made of and how they operate. Eventually they can try the "balloon smoking" to see the effects of smoking.

An idea that might help an occupational nurse comes from a project in Hampshire, England, where the employer agreed to invest money saved by ex-smokers. The decision was taken by the men after group discussion. One acted as a policeman and fined anyone he caught smoking.

You can help others by providing less opportunity for smoking. Request designated smoking areas in your place of employment for staff and public alike. This is already enforced in some institutions. In one hospital, patients are permitted to smoke only on the written permission of their physicians. There have been few complaints or abuses. Most people want an excuse to quit smoking, and a hospital could provide the chance.

Encourage your friends and patients to quit smoking; if they have tried and failed, persuade them to try again. The probability of success is greater for those who have quit once than for those who have never tried. Let us bury the peace pipe and declare war on our largest preventable cause of death.

#### References

- 1. West, Gordon, The smoker's progress 1556-1953. In *History of Smoking*. Published by Tobacco, London, 1953, p.29.
- 2. Ibid.
- 3. Ibid.
- 4. Ibid.
- 5. Ibid., p.30.
- 6. Ibid.
- 7. Wilson, W.M. Piping down the cen-

- turies. In *History of Smoking*, Published by Tobacco, London, 1953, p.75.
- 8 Ibid., p.74.
- 9. West, op. cit., p.33,34
- 10. Heimann, Robert K. *Tobacco and Americans*. New York, McGraw-Hill, 1960, p.103.
- 11. Ibid., p.250,
- 12. Ibid., p.251.
- MacLennan, Anne. Canadians most persistent smokers in the world, tobacco statistics show. *The Journal* 2:1:6, Jan. 1, 1973.
- Brody, Jane E. and Enquist, Richard. Women and Smoking. New York. Public Affairs Committee. 1972. p. 11-15. (Public affairs pamphlet no. 475)
- 15. Medical Bulletin on Tobacco 5:1. Spring 1967.
- 16. Dilemna. CTRDA Bull. 51:4:8. Dec. 1972.
- 17. Matthews. D.L. Opening statement, National Seminar on Smoking and Health. Saskatoon. Saskatchewan. June 6, 1972.
- Report on 1972 scientific sessions.
   Dallas. November 16-9. Heart Research News. 17:2; special issue, Fall/Winter 1972.
- Nonsmokers unite. Canad. Nurse 67:11:44, Nov. 1971.
- Lequette, A.G. et al, Some immediate effects of a smoking environment on children of elementary school age.
   J. Sch. Health 40:10:533. Dec. 1970.

Photograph on page 25 is reprinted, with permission, from *The Journal* of the Addiction Research Foundation, Toronto, Ontario.

## Detoxification: an alternative in transition

When the law was changed to allow police to take a drunken individual to a detoxification center instead of arresting him, some positive and some negative results ensued. The author discusses the problem of changing the behavior of alcoholized persons and maintaining the change that is achieved.

Frederick D. Funston

The term "alcoholization" describes a process in which drinking behaviors, including behavior while drinking, are learned by reinforcement.

As we are socialized and politicized, similarly we learn to drink. How we learn determines whether our drinking behavior, including behavior while drinking, is appropriate or inappropriate.

Drinking becomes a legitimate and singular vehicle for meeting an alcoholized person's needs, such as social participation, that he believes cannot be met without drinking. Once learned, this pattern of behavior is difficult to replace. As it develops, it is usually characterized by excess, which eventually leads to painful conflicts breakdown and loss of employment.

For example, a 40-year-old man, employed and married with two children, remained sober from Sunday afternoon until Friday afternoon. Then he would drink to excess on the weekends and express to his wife his negative feelings about their life-style.

On Sunday, he would stop drinking and apologize to his wife. She would reply consistently: "It's all right. I forgive you because, when you are not drinking, you are a good husband and a good provider." Under these circumstances, it is unlikely he will stop drinking so long as he has these feelings that he cannot otherwise express and so long as his wife does not hold him accountable or responsible for his drinking behavior. Because he has learned it is all right to behave this way when drink-

ing, he will continue as long as she continues to forgive him.

In this instance, therapeutic intervention was directed toward finding other ways in which he could express his feelings without having to legitimize his behavior and avoid responsibility by drinking. It is important to examine the consequences of a person's drinking, especially if intervention is considered. Intervention should find new ways of meeting a person's needs in a manner that is not only more satisfying to the individual, but also more acceptable to society.

In 1971 the Ontario law was changed to allow police officers to transport individuals, found intoxicated in public places, to a detoxification center in lieu of arrest. Before the change, responsibility for the management of the chronic drunkeness offender or homeless alcoholic rested largely with the police and other social control agencies. The process of repeated arrest and incarceration, which became known as the "revolving door," was at once helpful and hindering.

It helped those who were arrested, because they received compulsory detoxification as a result of their incarceration for 30 to 60 days. During these

periods in jail, they regained much of their physical health. There has been, and continues to be, considerable merit for the physical rejuvenation that can take place.

But it also hindered, because some of those arrested were new to the city and new to its "street life." Through the series of arrests and subsequent incarcerations, they were quickly introduced to the "street" subculture. During these times in jail, they met many of those who would become their future drinking companions.

Negative attitudes about society in general and the police, in particular, were quickly learned in jail. Thus the number of homeless alcoholics was continually replenished with new recruits found in the cells. In addition, because the change achieved in the cells was not voluntary, it was short-lived, since they usually returned to the streets with their newfound acquaintances.

For the police, the "revolving door" meant difficulties ranging from the amount of time spent in arrest and transportation, which could have been devoted to other activities, to the high number of suicide attempts in the cells by those charged with alcohol-related offenses. Although few agencies continue to see the alcoholized person as a criminal, it is unlikely that any agency other than the police will be able to assist as effectively in protecting them from accidental injury to themselves or to others.

Many of those seen for detoxification identify boredom and loneliness as two

Mr. Funston was head of the detoxification unit of the Clinical Institute, Addiction Research Foundation, Toronto, until July 1973. He is now studying for a master's degree in social work in New Orleans, La., U.S.A.

major areas of difficulty. If any treatment program is to interest this population, it must consider these problems and demonstrate some efficiency in resolving them.

#### **Detox center population**

The detoxification (commonly shortened to detox) center, associated with the Clinical Institute of the Ontario Addiction Research Foundation in Toronto, is the only unit in the southern part of Ontario that has detoxification facilities for both men and women. Based on preliminary statistics, the men and women have demographic similarities, but their behavior is quite different.

The women generally present more management difficulties than do the men, both during their admission and during their stay. The women are usually more abrasive, more aggressive and violent, and much more manipulative. They do not stay as long and are less willing to become involved in further treatment.

This may be due to several factors. First, society's expectation of the role of women is such that, once they are "on the street," they have lost more in status, both in their own view and in society's, than men in similar circumstances. Second, the women do not socialize among themselves or have the same camaraderie that is apparent in the male population. While the men who come to the detox unit often meet the same men they were drinking with several days previously, this is rarely the case for the women. Women tend to isolate themselves and are more difficult to engage in discussion.

Third, there are fewer treatment facilities available for women. Admittedly, there are substantially fewer females arrested for public drunkeness, but the nature and variety of available facilities are limited and, until recently, were primarily punitive.

Although this description may be characteristic of the population for which the system of detoxification centers was primarily established, we do see a cross section of the general population; it would be unreasonable to deny facilities to those who volun-

tarily present themselves for assistance and who are in no less need.

We have 20 beds, 15 for men and 5 for women. Of the 15 male beds, 8 are set aside for referrals from the police department only; four are set aside for referrals from our hospital, the Clinical Institute (a 100-bed teaching hospital dealing with the broad spectrum of alcohol and other drug problems), and three beds are set aside for referrals from other sources, including general hospitals, private physicians, and selfreferrals. The five female beds are all available for referrals from any source within the metropolitan area. The manner in which we have ordered our priorities for accepting referrals has determined, to a large extent, our population characteristics.

#### Admission criteria

As beds are available within our framework of priorities for accepting referrals, we admit all persons who require detoxification, provided they do not require immediate medical attention and are not presently in a state of severe withdrawal. If they require immediate medical attention, they are referred to the emergency department of the Clinical Institute. All admissions to the detox center are voluntary, and the maximim stay is seven days.

#### Center setting

The detox center is an older home, which has been renovated and refurbished to our specifications. We believe the physical environment can have a positive effect upon residents. Since detoxification centers must aim to facilitate comprehensive treatment and support for their residents, or risk becoming just another part of the "revolving door," the treatment setting (including staff, program, and physical environment) must act in concert to promote residents' involvement in ongoing treatment.

Efforts have been concentrated on establishing and maintaining an environment that implicitly conveys to the residents our positive feelings about their personal worth and their ability to progress with help. Since detoxifica-

tion often represents the first stage in the treatment continuum, we have attempted to create an attractive residential setting that will facilitate the alcoholized person's initiation into an ongoing treatment process.

#### **Detox program**

Because we assume that alcoholized behavior is learned, strong emphasis is placed on planning future goals with the individual. We use a goal-oriented approach rather than a problem-oriented or problem-solving approach.

Although we seek to define the individual's needs and to help delineate ways in which the needs can be met, we find that making a decision about what follows detoxification gives more meaning and purpose to this sometimes difficult period for the resident. We can only outline the kinds of changes that appear necessary for individuals to realize their stated goals, and the various kinds of assistance available to help them do so. We attempt to do this by both individual and group counseling and through a program of activities.

The extent of residents' involvement depends a great deal on their physical well-being. We have found that approximately two days after admission the majority of residents are able to begin to discuss future plans. The degree of discomfort associated with the withdrawal of alcohol may vary substantially from individual to individual, but such withdrawal as it occurs is generally characterized by tremulousness, nausea, vomiting, diarrhea, weakness, perspiration, fever, anorexia, insomnia, visual and auditory hallucinations, disorientation, and possible convulsions.\* However, severe withdrawal does not occur in most admissions for detoxification.

Participation in the program is voluntary and activities that are assigned are matched to the individual's health and ability. All the housekeeping in the

<sup>\*</sup> Isbell, H. et al, An experimental study of the etiology of "rum fits" and delirim tremens, *Quart. J. Stud. Alcohol* 16:1:1-33, Mar. 1955.

unit is the responsibility of the residents. They also prepare their own breakfasts and lunches; the evening meal is prepared at the Clinical Institute

and sent to the center.

In addition, the center has recently begun a workshop program in cooperation with the Kiwanis club and the Salvation Army. Each year the Kiwanis club collects toys, which the Salvation Army distributes to needy families at Christmas time. Many of these toys need repair and we have volunteered

to help repair them.

Aside from the service provided to the community, this is helpful for residents because it is a meaningful activity that provides relief from boredom and a new way of being with others without having to drink. The diversity of the tasks and the differing degree of manual dexterity means there can be something for everyone to do. In this way, we can demonstrate to residents that they are capable of meaningful activity and that they can be productive. We thereby hope to increase their sense of personal worth. We can then say to them: "If you have achieved this much in such a short period, during the initiation of treatment, think what you might gain by becoming involved in further treatment and support!"

#### Referral after detoxification

To those who decide to accept a referral for comprehensive treatment, we can offer outpatient and inpatient care at the Clinical Institute, halfway house facilities for both men and women, outpatient contact at any one of the branches of the Addiction Research Foundation throughout the province, and for the men, an industrial farm setting, Bon Accord, plus all the treatment services available in the community for both men and women, such as Alcoholics Anonymous.

In addition, if the individual is not interested in a referral at the time, we attempt to make arrangements for accommodation, food, and clothing and encourage him to return if he changes his mind.

We do not limit the number of times a person may be admitted, solely be-

cause of the number of prior admissions. We do refuse to admit persons if they have been violent or unmanageable over several admissions. Generally, however, we will continue to accept persons for admission, despite repeated admissions, because we feel this gives us an additional opportunity to work with someone who is very much in need of help. To deny him admission would be to say "because you have a problem, we are no longer prepared to help you."

The "revolving door" of repeated arrest and incarceration has been too narrowly defined and should be expanded to include a cross section of all service agencies, since many of the persons seen in detoxification centers have contacts over a number of years. Previously the assumption seems to have been that the most effective deterrent, provided by what was assumed to be solely a legal model, was a deterrent from treatment.

Consequences of change

As a result of the introduction of detox centers, the courts are no longer proceeding in the same manner with the prosecution of those charged with public inebriation. A period in jail was routine before, but it now appears that detoxification centers are assumed to be handling the problem. Thus, to give one man a sentence of incarceration, while another goes to a detox center, appears to the courts to be grossly unfair. This has led to many suspended sentences, and, subsequently, to an additional problem.

Previously, periods of incarceration acted as a form of compulsory detoxification and physical rehabilitation. Now that this has been removed and detoxification is voluntary, many persons choose to leave the detox center after only a short period of rest and recuperation. We run the risk of having many, less healthy persons in this population.

Therefore, there is a great and pressing need for detox centers to reevaluate their programs and to keep close and careful watch on the physical well-being of the residents in their care, to prevent serious debilitation.

Detoxification centers were established with the belief that a lack of treatment opportunity, or even contact with treatment resources, perpetuated the problems of this population. Accordingly, detoxification centers were to be vehicles that would make treatment opportunities more readily available; it was assumed that the alcoholized population would naturally be interested in treatment. This has not been the case.

It may be due to several factors. Prior experiences in treatment may not have been successful in terms of the individual's expectations, and he may have been discouraged from further attempts. Or, the result of treatment may not offer a significant change for the individual. Even though, for example, he might get a good job, he will likely return to his old behavior if he is still lonely.

Although the original idea of detoxification centers was unstructured, informal, and low-key residential settings, that position needs reevaluation since only a small proportion of those who are referred for detoxification are interested in accepting a referral for further treatment.

Because the role of these centers is to draw more individuals into treatment, detoxification centers should intensify their programs to demonstrate to their residents that not only is change possible in a short period of time, but there are alternatives to their present life-style that can be even more satisfying and are achievable, given adequate support.

A significant change in a resident's behavior takes place following withdrawal. We believe that this change is not unique to the detox center setting. A high degree of adaptability is evident alcoholized persons' behavior, whether in a hospital, a jail, a detoxification center, or on the street. They quickly learn what is expected of them in each setting and behave accordingly. The problem thus appears not to lie in changing their behavior, but in maintaining the change that is achieved. 😂

# Genetic manipulation:

### now is the time to consider controls

Louis Siminovitch

In recent years society has become increasingly aware of the schizophrenic nature of scientific discovery. While most of us would not willingly relinquish many of the fruits of scientific invention, we have become more and more cognizant of the potential misuses of every such advance. Unfortunately, in most cases, society awakens to these hazards long after they have first been observed, and usually only after the discovery has been exploited. At this stage the progress of events is often so inexorable that moderation or outright prohibition is just not possible.

Recent advances in genetics again raise the spectre of the potential misuse of science. Progress in this field has been far-reaching and certainly more rapid than most scientists anticipated: the prospects for genetic manipulation in man now, or in the near future, do not seem nearly as illusory as they did a few years ago. In fact, in genetics, what was once science fiction is now science. And what is now science fiction may be science a few years hence. Nevertheless, genetic manipulation in man is not yet practiced on a large scale. And this perhaps presents us

Dr. Siminovitch is professor and chair-

man of the department of medical genetics at the University of Toronto, and genewith a unique situation: it may be possible to predict before—rather than after—the event how discovery in genetics will proceed, and how it will be exploited.

There is thus time to consider some of the probable scientific consequences, there is time to consider whether mechanisms should be developed to deal with these advances, and, most important, there is time to consider what mechanisms or social structures would best be suited to handle the scientific realities when they come to pass. Since society finds it difficult to cope with potentially self-destructive events in any area, the prognosis may not be too encouraging. However, although scientists, particularly geneticists, will have to play a role in these deliberations, their expertise does not extend to the moral, ethical, or social consequences of scientific discovery. In fact many would argue that because of their parochial interests, scientists are rendered less than objective in such matters.

These considerations make it important to discuss the prospects of genetic manipulation in man in as broad a forum as possible, including the medical profession, the lay public, and government. Although there might be some disagreement about which types of genetic manipulation are most imminent or which pose the greatest prob-

lems from the ethical and social point of view, there is consensus that the three major areas of concern include:

- ☐ the use of nuclear transplantation to produce multiple copies of identical organisms (cloning);
- Ithe potential genetic manipulation associated with test-tube fertilization of the human ovum and reimplantation into the uterus;
- The diagnosis of genetic disease prenatally by biochemical or cytogenetic analysis of amniotic cell samples early in pregnancy and grown in the laboratory (amniocentesis).

The state of sophistication of each of these procedures in respect to genetic manipulation in man is quite different. Amniocentesis is being practiced now. Test-tube fertilization and early development is also possible now, but the likelihood of genetic manipulation in this system is some years away. Cloning is not now possible in man and its application is not likely to be attempted in man for some years to come.

In assessing the possible impact of genetics, therefore, it is probably most important to consider procedures that either are relevant now (amniocentesis) or may become relevant soon (fertilization in vitro). This does not impose a serious limitation in the scope of the discussion, since nearly all the ethical, moral, and social problems surface in considering the two procedures mentioned. At the same time, the potentialities of cloning should not be disregarded, since the evolution of mores

ticist-in-chief of the genetics department at the Hospital for Sick Children.

Toronto, He is also a founding member of the editorial board of Science Forum.

Reprinted from Science Forum, June 1973, with the permission of the Editor.

30 THE CANADIAN NURSE

**NOVEMBER 1973** 

and ethics cannot be predicted, and what may be anathema to our society today, may be considered justifiable to others, perhaps at another time.

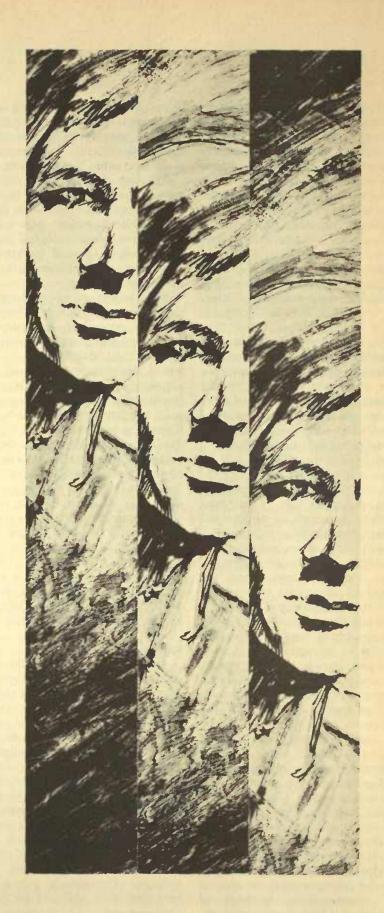
#### Fertilization in vitro

Fertilization in vitro has been possible with animals for a number of years, but it has only been recently that the same result has been achieved with man. The major studies have been done by R. B. Edwards and his group in Cambridge, England. Briefly, it is now possible to sample suitably prepared oocytes from a woman by laparoscopy, and to fertilize these with sperm in culture vessels under carefully controlled conditions. The fertilized egg is then able to divide and develop to what is called the blastocyst stage, which consists of sixty-four cells. Although the work is difficult and requires exceptional technical skill, the experiment basically is quite simple.

In animals, groups of cells at a similar stage in development can be reimplanted into the uterus and they then develop further into what seem to be normal animals. Thus the full cycle can be achieved. In man, the original impetus of the work from the medical point of view was to allow women with blocked oviducts the opportunity to bear children, and in fact most of the volunteers for the experiments, if not all, have been women with such a defect. As far as is known, the full cycle (fertilization, development, reimplantation in utero, and full development) has not yet been achieved in man, perhaps because it has not been attempted, or perhaps because the procedure has failed at the reimplantation stage or later.

The development of this expertise poses serious questions. In terms of social benefits, it promises hope for women with blocked oviducts who desire their own children; it offers an experimental system to examine problems of both conception and contraception under controlled conditions in the test tube; since the sex of the cells in the blastocyst can be determined relatively easily, and since a number of diseases are sex-linked, it offers the possibility of choosing only the blastocyst of appropriate sex for reimplantation.

On the other hand, the problems engendered by these achievements are many and complex. Many of the ethical problems have been raised by Paul Ramsey, Leon Kass, and others. First, NOVEMBER 1973



there is the safety of the procedure itself. Even under natural conditions, congenital errors in development are not infrequent. The so-called experimental system involves many stages, most of which are ill understood. Is it valid then to engage in such experimentation in man, even under conditions of consent, especially when suitable comparable systems are available in animals?

Second, Ramsey questions whether this procedure falls within the normal prerogatives of the practice of medicine, in the sense that it is satisfying the desire of human beings rather than practicing the art or science of healing. Some would argue with this equivocation. Nevertheless, one can question whether extensive resources should be directed to this objective when there is so much concern about overpopulation, and when adoption is also possible, albeit rather difficult at present.

Assuming that the full cycle will be achieved, it is perhaps more important at this stage to consider the implications of the procedure of test-tube fertilization in respect to its potential for genetic manipulation in man. The availability of the sperm and the unfertilized oocyte, early in the procedure, provides a potential opportunity for various types of genetic intervention. In a positive sense, since a plethora of diseases are genetically determined, it may be possible to correct these defects by transfer of the appropriate genetic material into the eggs, sperm, or zygote, when suitable technology is available. The transfer of genetic material from one cell to another has been possible with bacteria for a number of years. While such procedures are not yet possible with animal cells, extensive experimentation is under way seeking to develop them.

The technology is similar to that used with bacteria, and involves the use of appropriate nucleic acids, viruses, chromosomes, and certain types of cell manipulation. At the same time, knowledge is accumulating about the location of different genes on specific human chromosomes, methods of removing nuclei from mammalian cells, and other procedures that will be needed

if genetic manipulation is to be attempted. Some sorts of manipulation of this type are already being attempted in mouse cells in early development, and some success has been achieved.

Although the emphasis above has been on the potential use of these gene transfer techniques to cells in early stages of development, there are some who believe the technology, if and when it is developed, could be applied in some form of gene therapy to the somatic cells of adult man.

It is important to emphasize that most, if not all, of this experimentation is being done with the purpose of achieving a better understanding of cell function and development — its potential application to genetic manipulation in man is not yet contemplated seriously. It is also important to point out that even if transfer of genetic material at early stages of development were possible, a number of other technological problems would remain in respect to practical application. Nevertheless, it is obvious that the possibility of success all along the line provides the medical scientist with the potential, not only to prevent certain genetic disease, but also to alter the human genetic pool. In essence, such "achievements" would provide man with the prerogative of designing his own heredity, rather than using the present lottery system of chance mating.

#### **Amniocentesis**

It is perhaps unduly alarmist to be concerned with genetic manipulation of the type just described, since the obstacles may be insurmountable both from the technological and ethical or social point of view. However, there is a second area of genetic manipulation, which is already being practiced, and which poses ethical and social problems of a different but overlapping kind. This is the use of amniocentesis as a procedure for the diagnosis and prevention of genetic disease. In this procedure, cells are sampled from the amniotic fluid early in the second trimester of pregnancy, grown in culture, and then analyzed for either a chromosomal or a biochemical defect.

Down's Syndrome or Mongolism,

which results from the presence of a specific extra chromosome and becomes more frequent with increased age of the mother, is a typical example of a chromosomal defect that can be diagnosed by this procedure. Galactosemia is a disturbance of sugar metabolism which, if not treated by special diet very early, leads to a series of abnormalities, including mental retardation. It is inherited as a recessive gene and is found with a probability of one in four in children of parents who each carry one mutant copy of the gene. This disease is an example of a biochemical defect that can be ascertained in amniotic cells; there are about forty others.

The potential benefits of amniocentesis are easily apparent. The procedure offers an effective method to reduce the incidence of severe debilitating genetic disease, and is therefore an extremely important form of preventive medicine. But the practice brings with it several ethical and social questions. These are of two major kinds: societal problems associated with the introduction of the procedure, and problems inherent in the operation of amniocentesis programs. In the former case, as Kass has pointed out, one must be cognizant of the fact that no matter how wide the sereen, and how valid the indications, large numbers of potential parents will not have an amniocentesis done, either by design or by accident. Will society's attitude to such children be less tolerant, or will parents feel increased guilt for defective children born under these circumstances? Since it is difficult to establish absolute sets of values in areas such as these, is one justified in concluding that defective children represent a blight on family or society?

Perhaps the major conclusion that one should derive from considerations such as these is that the practice of genetic amniocentesis will have its impact on social values. It is important, therefore, that medical scientists and the lay public be made aware of this, and measures should perhaps be evolved to ensure that these social factors are constantly kept in mind when such procedures are introduced and

practiced.

Genetie amniocentesis programs already are in operation in Canada, the United States, and Europe. However, there is really no consensus about who should be offered the diagnostic procedure, and how it should be offered. Several factors enter into such decisions. In general, these involve the balance between the safety of the procedure and the breadth of the screen for prospective genetic disease, the balance between social benefits to parents and family and the possible negative effects on social values of using the procedure for trivial indications, and finally that cliché of modern social dynamics the balance between economic costs and benefits. These dialectics are best illustrated by specific problems.

One of the major reasons for considering the use of genetic amniocentesis is the possibility that a mother might bear a child with Down's Syndrome. The incidence of this chromosomal disorder increases with the age of the mother; although the estimates vary, at age forty about one in forty fetuses will be affected, and at age thirty-five about one in 300, while at lower ages the incidence is much less. There is general agreement that the high incidence of this defect at age forty and over justifies the attempt at diagnosis by genetic amniocentesis in such potential mothers. However, the problems arise at age thirty-five or less. For example, no medical procedure of this kind is without risk and there is some finite possibility that the act of sampling for amniotic cells will result in some difficulty either for mother or child. (It must be kept in mind that the very large majority of diagnoses will indicate a normal fetus, and therefore pregnaney will proceed to term.) Unfortunately, since the procedure has been used for genetic diagnosis for only a few years, no good data are available on such risks. Present indications are that the risks are very low. Information is being obtained, but in this instance the experiment must be done on man with the very people to whom the procedure is being offered. Considering only safety, therefore, how broad should the screen be at this time?

These age-related factors also enter into consideration of the economic costs and benefits. The economic burden of raising a mongoloid child is very large, and of course each procedure will have a finite but much lower cost. In Canada we have very poor data, if any, on each of these figures, and obviously such information should be obtained. It seems certain that for mothers of age forty or over the economic benefits will far outstrip the costs. But at age thirty-five or lower the economic equation becomes more balanced, and then it becomes questionable whether one should use a measurable portion of our health industry dollars (and manpower) for this type of health care, instead of other types.

The second major impact of genetic amniocentesis lies in the diagnosis of specific biochemical defects. Two examples will illustrate the problems. Tay-Sachs disease leads to a progressive degenerative condition that results in mental retardation and early death. It is inherited as a recessive gene so that parents in whom only one of the two copies of the gene is defective are normal, whereas children with two bad copies manifest the disease. Furthermore, there are biochemical tests whereby both the carrier parents and the affected children can be recognized. This disease is prevalent in Ashkenazi Jews, the major Jewish population in North America, so that one can screen a relatively well-delineated population for carriers, and thus recognize couples in which both parents carry one defective gene. In the past, the role of the physician or genetic counsellor in such cases was solely to indicate to the parents that their chances of bearing a Tay-Sachs child was one in four. With the advent of genetic amniocentesis, it is possible to determine during pregnancy whether a fetus is defective. Parents, therefore, have the option of terminating such a pregnancy through abortion and trying again for the three-quarter probability of having an unaffected child.

Clearly, this is an ideal use of genetic amniocentesis. Both the social and economic yields are high. The same could be said for galactosemia, which

can also be diagnosed in utero. The probability of bearing an affected child is one in four for parents who have already had one child or more showing the syndrome. There is good evidence that diagnosis and diet control begun during gestation are important in reversing the clinical manifestations of this disease. It is, therefore, useful to offer amniocentesis to parents who are known to carry one copy cach of the defective gene. But, as with chromosomal disorders, one is again faced with the problem of deciding on the breadth of the screen.

Although Tay-Sachs, for example, in generally recognized as a severe genetic disorder, many other diseases will be less severe and more or less treatable. Cystic fibrosis is a very common genetic disease, but there is a great variation in the severity of the symptoms. Treatment has been improved considerably, and some children can eventually lead almost normal lives. There is no method for diagnosis of cystic fibrosis in utero as yet, but it seems probable that there soon will be. Perhaps once again there would be a consensus that genetic amniocentesis should be offered in this case. But the problem is obvious. More and more diseases of varying severity will become diagnosable in this way. Should there be a dividing line, and if so, where should it be drawn?

These examples illustrate some of the practical problems facing those offering genetic amniocentesis. Clearly, some consensus on where to draw the line will have to be obtained. But there are also some more general issues of the following kinds:

- Assuming guidelines have been established for the cases illustrated above, how does one deal with those involving psychological stress or anxiety, where the mother or parents do not fit into the defined categories, but for various reasons they (or their families) are inordinately fearful of bearing a defective child?
- Since genetic amniocentesis can be a cost-reducing procedure in certain clearly defined cases, how does one ensure that it does not become an obligatory diagnostic procedure for

parents in such groups? This is particularly pertinent where the procedure runs counter to religious or ethical beliefs.

Genetic amniocentesis, if it is to be carried out well, involves the combined talents of physicians and scientists of several disciplines. No mechanism exists at the moment to control the quality of the service, let alone the particular ethics or social responsibility of individual groups. Should such mechanisms be developed in Canada, and how?

Since genetic amniocentesis is a relatively sophisticated procedure, and therefore not well recognized by the general public as being available at present, is there a responsibility to communicate such information as widely as possible? And whose

responsibility is it?

Since the procedure is being financed by the public, does everyone have a right to genetic amniocentesis, for reasons however trivial, e.g., for sex determination, and regardless of guidelines?

In considering all of these problems, it should be recognized that genetic amniocentesis was introduced in response to a need as defined by medical scientists. This is, of course, not unique and, in fact, is probably a necessary mechanism for introducing innovation and progress into medical care. But the issues discussed here raise the question whether such decisions should be left to medical scientists.

There is probably general agreement that the advent of procedures, such as genetic amniocentesis and test-tube fertilization, with the associated advances in knowledge of the genetics of mammalian cells, offers both serious challenges and difficulties for medical scientists and the public at large. Having raised these problems and perhaps, in some areas, ventured into the realm of science fiction, one may question whether any immediate societal response is needed or justified. Certainly few would seriously seek to interfere with studies on test-tube fertilization, genetic manipulation of mammalian cells, or, for that matter,

with studies to increase the sophistication of diagnosis of genetic or developmental disease in utero. Even if this were considered desirable in our society, different ethical and social attitudes throughout the world, as well as other factors, would seriously reduce the efficacy of any such decision.

And certainly one should first recognize and emphasize the many positive features of our increasing sophistication in genetics. For such sophistication can, if used well, enable man to understand and cope with a broad varicty of diseases. But with this power comes responsibility, and the issue now is whether our social institutions arc sufficiently developed, experienced, or concerned, to deal with such problems effectively. Sinsheimer has expressed the dilemmas very well:

How shall we confront this very new human potential? Clearly we will need more than accepted custom, more than another law, more than technology assessment. We shall need a basically new vision and an adaptive philosophical stance.

For all the ancient and unresolved human dilemmas arise again, to be seen in a new light which more fully exposes their true dimensions; the welfare of the individual as against the welfare of the group, the welfare of the unborn and our debt to future generations, the welfare of the fetus and the sanctity of life; the issue of human primacy - the control of men over each other - and its reflection in human experimentation; the concept of normality and the tolerable range of human diversity; the tenuous balance between the power of knowledge and the knowledge of responsibility.

These considerations suggest strongly that more is required of us than idle curiosity and discussion. In the case of genetic amniocentesis, surely those involved in health care (for example, government, communities) bear some responsibility in some areas alluded to earlier. Since the problems raised here are not unique to genetics and will become increasingly serious with time, mechanisms should be developed on a provincial (if not national) scale to

keep these problems under review and to make information available to all who want it.

One hesitates to recommend a dominant government role in this area. But it seems possible that in the absence of any other coordinating body, if anything is to be done some initiative will have to come from government. And the sooner the better. For it seems clear that man is developing more and more the power to control his own destiny, and one should perhaps always be aware of the thoughts of C. S. Lewis in his treatise on The Abolition of Man.

What we call Man's power over Nature turns out to be a power exercised by some men over other men with Nature as its instrument . . . If any age really attains, by eugenics and scientific education, the power to make its own descendants what it pleases, all men who live after it are the patients of that power... Each new power won by man is a power over man as well. Each advance leaves him weaker as well as stronger.



Why not have the "black and white cocktail" served in your hospital in the Patient Cup™? The wide-mouth opening of this liquid unit dose container makes it easy for the patient to drink ORGANON'S smooth suspension of Milk of Magnesia and Cascara. (It's pleasant tasting, too.)

Each Patient Cup delivers a stable, precise dose of Magnesium Hydroxide (8%) equivalent to 30 ml. Milk of Magnesia U.S.P., and Cascara Extract equivalent to 5 ml. Aromatic Cascara Fluid extract U.S.P. Alcohol 3.5%.

No mixing. No pouring. No waste. Here is another opportunity for your pharmacy to extend its control of medication right up to the administration of a single dose. And, you'll make some more friends in the nursing department as well.

Order several shippers of Milk of Magnesia-Cascara Suspension. There are 100 doses in each, packed 10 to the shelf tray.

Set 'em up!



The Patient Cup



ORGANON CANADA LTD/LTÉE

INTRA MEDICAL PRODUCTS DIVISION TORONTO, CANADA

#### names



Phyllis Barrett has been appointed executive secretary of the Association of Registered Nurses of Newfoundland, replacing Pauline Laracy who had held that position from the time the associa-

tion was formed in 1953.

Ms. Barrett (R.N., St. John's General Hospital school of nursing; Dipl. Nursing Admin. and Educ., U. of Toronto; B.N., Memorial U., St. John's, Nfld.) is immediate past president of the ARNN and a former assistant executive secretary of the association. Prior to her marriage, she had been head nurse, instructor, then director of nursing at the St. John's General Hospital.

More recently, Ms. Barrett has been instructor of nursing at the Grace General Hospital and guest lecturer at St. Clare's Mercy Hospital in St. John's.



Ann Dorothy Shaw has been appointed public relations officer of the Alberta Association of Registered Nurses, succeeding Robert Donahue who recently transferred to the employment

relations department.

Ms. Shaw (B.A. U. of Reading, England) has been an editor with the provincial department of education and, more recently, has been in the publications department of the Alberta Teachers' Association.

Among her duties, Ms. Shaw will have responsibility for the monthly newsletter and for coordinating the annual convention.

Beverley M. McCann is the recipient of the 1973 bursary for graduate study in nursing offered by the Ontario division of the Volunteer Nursing Service Committee of The Canadian Red Cross Society.

Ms. McCann (Reg.N., The Hospital for Sick Children school of nursing, Toronto; B.N.Sc., Queen's University, Kingston, Ont.) will use the \$1,000 bursary toward the degree of master

of science in nursing (education) at the University of Western Ontario, London.

Maude Dolphin (R.N., Royal Victoria Hospital school of nursing, Montreal; B.N., McGill University; M.N., University of Washington, Seattle) is now director of nursing at Maple Ridge Hospital, Maple Ridge, B.C. She has been assistant professor on the nursing faculty of the University of British Columbia and of the University of Toronto school of nursing.

Ms. Dolphin's earlier career has included several years under the auspices of WHO as nurse educator in

Pakistan, Syria and Mauritius.

**Eleanor Mitchell,** a former assistant editor of *The Canadian Nurse*, has been appointed director of volunteer nursing services of the Ontario division of the Canadian Red Cross.

Ms. Mitchell earned her Reg.N. at Toronto General Hospital school of nursing, B.N. at McGill U., Montreal, and studied at the Montreal Neurological Institute. During her career, she has been staff nurse, nursing education assistant director, teacher of nursing, and nursing office supervisor.

Sylvia Diane Paulson has accepted a two-year appointment as assistant professor, school of nursing, University of British Columbia, Vancouver.

Ms. Paulson (B.S. in Nurs., Pacific Lutheran University, Tacoma, Wash.; M.N., U. of California, Los Angeles) has been a public health nurse and instructor of nursing in Tacoma; a clinical specialist at Los Angeles County Hospital — USC Medical Center; and nurse consultant at the San Diego Regional Center for Medical Research.



Nicole Du Mouchel, R.N., M.N., has been promoted to the rank of major in the Canadian Forces Reserve, effective last August 1. Ms. Du Mouchel is the executive director and secre-

tary-registrar of the Association of Nurses of the Province of Quebec. L. Joan McCullagh has been appointed an assistant director of education services at RNABC provincial headquarters in Vancouver.



Ms. McCullagh (R.N., St. Paul's Hospital school of nursing, Vancouver; B.S.N., U. of British Columbia; B.A., U. of Victoria) has completed studies and a thesis on Canadian literature

toward a master's degree at UBC.

Ms. McCullagh has been the senior instructor in psychiatric nursing for the Mental Health Branch psychiatric nursing program of the government of British Columbia. She was responsible for the planning, implementation, and supervision of the psychiatric part of a revised two-year program for psychiatric nurses.

Muriel E. Small (R.N., Montreal General Hospital school of nursing; B.Sc. N., McGill U.; M.Sc.N., U. of Washington, Seattle) has been appointed to the new Health Services Commission of Nova Scotia.



During her career, Ms. Small has worked with displaced persons in Austria with UNRRA. done field work with the department of public health in Vancouver, been associate professor,

University of Toronto, faculty of nursing, and taught public health nursing at Dalhousie University school of nursing. At present, she is engaged in research at Dalhousie University and as a consultant at Mount St. Vincent University.

Jessie Hibbert, of Medicine Hat has been appointed to the provincial mental health advisory council of Alberta. She is one of 14 who will serve on council under chairman Dr. W.R.N. Blair, author of the Blair report on mental health.

A nursing instructor at Medicine Hat College, Ms. Hibbert represents the Alberta Association of Registered Nurses on the council.

NOVEMBER 1973

# What the well-bandaged patient should wear:

Bandafix is a seamless round-woven elastic "net" bandage, composed of spun latex threads and twined cotton,

Bandafix has a maximum of elasticity (up to 10-fold) and therefore makes a perfect fixation bandage that never obstructs or causes local pressure on the blood vessels.

Bandafix is not air-tight, because it has large meshes; it causes no skin irritation even when used for the fixation of greasy dressings. The material is completely non-reactive.

Bandafix stays securely in place; there are eight sizes, which if used correctly will provide an excellent fixation bandage for every part of the body.

Bandafix does not change in the presence of blood, pus, serum, urine, water or any liquid met in nursing.

Bandafix saves time when applying, changing and removing bandages; the same bandage may be used several times; it is washable and may be sterilized in an autoclave.

Bandafix is an up-to-date easy-to-use bandage in line with modern efficiency.

Bandafix replaces hydrophilic gauze and adhesive plaster, is very quick to use and has many possibilities of application. It is very suitable for places that otherwise are difficult to bandage.

Bandafix is economical in use, not only because of its relatively low price but because the same bandage may be used repeatedly.

Bandafix does not fray, because every connection between the latex and cotton threads is knotted; openings of any size may be made with scissors or the fingers.

# **Bandafix**\*

Distributed by

675 Montee de Liesse, Montreal 377, Quebec

\*Registered trademark of Continental Pharma.

### books

The Clinical Nurse Specialist: Interpretations, edited by Joan P. Riehl and Joan Wilcox McVay. 507 pages. New York, Appleton-Century-Crofts, 1973

Reviewed by Olga Darcovich, former Clinical Specialist, Health Sciences Centre, now faculty member, School of Nursing, McMaster University, Hamilton, Ontario.

Riehl and McVay have compiled a selection of readings about or related to the clinical nurse specialist. This collection includes reprints of recently published works and articles by invited authors. The articles have been carefully chosen to ensure that the variety of trends in and opinions about clinical nursing specialization are represented. They are grouped according to the perspectives of the past, present and tuture.

Most of the articles deal with the current situation, including educational preparation. practice, and research. Several articles discuss the clinical specialist working in the community or ambulatory setting, but most concern the clinical specialist in the hospital setting.

This book provides a useful account of the possibilities and the problems of nursing specialization. Of particular interest and significance is the section on research. In this section, Padilla's critique of five experimental studies on role effectiveness of the clinical nurse specialist is a gem, and could serve as a reference for nurses interested in research evaluation, as well as those interested in the clinical nurse specialist.

I wonder if anyone other than a reviewer reads every article in a book of readings in the sequence arranged by the editor? (The pieces in this collection can stand on their own and the reader should find no difficulty in "dipping" into the book as interest directs.) Reading sequentially, I found myself asking, "What is happening to nursing pratice?" It is to this larger issue that the final section, "The Future," seems to be addressed, leaving the reader to speculate on the fate of the clinical nurse specialist as we now know her/him.

Some of the influences and issues discussed in the last section are clearly

peculiar to the American scene. Indeed, with one exception, all articles in the book are based on the American experience with clinical nurse specialists. It's an observation to keep in mind when reading the book, but one that does not detract from the book's value to nurses on this side of the 49th Parallel.

The Clinical Nurse Specialist: Interpretations succeeds, as its editors intended, as a reference book about the clinical nurse specialist. As such, it should appeal particularly to present and prospective clinical nurse specialists, educators, and employers of nurses. Readers looking for the definitive work on clinical nurse specialists will be disappointed, but those seeking informative, stimulating and, at times, provocative writings on that subject should find the book rewarding.

Child Behavior Modification: A Manual for Teachers, Nurses, and Parents by Luke S. Watson, Jr. 147 pages. Toronto, Pergamon of Canada Ltd., 1973.

Reviewed by Ruth M. Pallister, Assistant Professor, School of Nursing, McMaster University, Hamilton, Ont.

This manual is designed for persons without formal educational background in psychology or behavior modification. It is purported to be a teaching manual, useful to those involved in the care of mentally retarded or autistic children demonstrating inappropriate behavior patterns. The text is based on principles of behavior modification employing the operant conditioning approach. However, the discussion of principles is purposely superficial. The reader is provided with definitions of terms and application of these terms in simple, everyday examples.

The content of the manual is presented in a didactic, though readable, manner. The 10 chapters are designed to develop the reader's knowledge gradually through building on previously presented content. Understanding of content is examined through a series of self-testing questions that conclude each major topic section.

From a general introduction in the first two chapters of behavior modification concepts and the rationale for

the use of techniques derived from this theory, the reader is led through a series of chapters dealing with the operant conditioning method for developing voluntary behavior in people. Simple behavioral examples highlight the discussion of concepts and provide a relief from the technical material.

Chapter 10 identifies the need for objective evaluation to determine the influence of treatment on the child. Four types of data collection techniques are described with graphic examples of each. The manual concludes with a glossary of terms and a bibliography.

While the author frequently employs the word "training" in his explanation of the use of operant conditioning, it cannot be said that his interpretation of this method is devoid of human feeling nor that he is promoting a general application. He emphasizes both the need to establish a relationship with the child as well as the importance of designing individual programs.

This manual should provide a useful guide in a teaching program that is concerned with helping persons of any age develop more appropriate behaviors. It is doubtful, however, that merely learning the contents of this book will enable the reader to be an effective behavior modifier. It is recommended that it be used in conjunction with clinical experience, expert supervision, and additional theoretical resources.

The Care of Your Colostomy, 2ed., by J.C. Goligher and Muriel Pollard. 31 pages. London, England, Baillière Tindall, 1973, and

Essentials of Abdominal Ostomy Care by Henrene Honesty. 92 pages. New York, Springer. Canadian Agent: Lippincott, Toronto, 1972. Reviewed by Dianne E. Garde, Certified Enterostomal Therapist, Mississauga, Ontario.

It would appear that a good deal of thought has been put into the booklet, *The Care of Your Colostomy*, as well as drawing on considerable experience from previous colostomates. The general information and hints make good reference material for the patient, but some of the suggested appliances

(Continued on page 40)

# Saunders'73

#### Books you'll turn to in '74...'75...'76...'77...

#### Phillips & Feeney: The Cardiac Rhythms

A Systematic Approach to Interpretation

A unique self-teaching guide to the recognition and interpretation of cardiac arrhythmias. Examines the effects of cardiac drugs and autonomic nervous system on arrhythmias. By Raymond E. Phillips, M.D., and Mary Kay Feeney, R.N. About 320 pp., 400 ills. About \$10.05. Just Ready. Order no. 7220.

#### Marlow: Textbook of Pediatric Nursing-4th Edition

Remains unexcelled in its comprehensive treatment of the growth, development, and nursing care needs of children from birth through adolescence. By Dorothy Marlow, R.N., Ed.D. 776 pp. 311 ills. \$11.10. May 1973. Order no. 6098.

#### Bermosk & Corsini: Critical Incidents in Nursing

Offers a nurse new insights on how to handle the varied humanrelations problems that confront her each day. By Loretta Sue Bermosk, R.N., M.Litt.; and Raymond J. Corsini, Ph.D. 369 pp. \$11.85. June 1973. Order no. 1696.

#### Asperheim & Eisenhauer: Pharmacologic Basis of Nursing Care—2nd Edition

Offers a complete outline of pharmacology and nursing principles for the busy practicing nurse. Discusses the nurse's role in drug therapy and devotes coverage to principles and techniques of administration. By Mary K. Asperheim, R.N., M.D. and Laurel A. Eisenhauer, R.N., M.S.N. 526 pp. Illustd. \$8.25. January 1973. Order no. 1436.

#### Stevens: The Practical Nurse in Supervisory Roles

A clearly written new book that helps the practical/vocational nurse accept the challenge and responsibility of supervisory roles. Ideally suited for nursing homes, extended care facilities and acute-care hospitals. By Marion K. Stevens, R.N., B.S. 131 pp. Illustd. Sept. 1973. \$4.65. Order no. 8591.

#### Irving: Basic Psychiatric Nursing

Details the basic duties, responsibilities and types of nursing care In today's psychiatric nursing. By Susan Irving, R.N., M.S. 319 pp. Soft Cover. \$5.10. January 1973. Order no. 5045.

#### Gillies & Alyn: Saunders Tests for Self-Evaluation of Nursing Competence—2nd Edition

Provides an easy and reliable volume for review and examination of nursing methods, professional skills and medical facts. By Dee Ann Gillies, R.N., Ed.D. and Irene B. Alyn, R.N., Ph.D. 392 pp. plus 152 answer sheets. \$7.75. January 1973. Order no. 4131.

#### Harrington & Brener: Patient Care in Renal Failure

A thorough guide to treatment of patients with kidney disorders. Covers hemodialysis, peritoneal dialysis, transplantation, and conservative methods of correcting renal failure. By Joan D. Harrington, R.N., M.S.N., M.A. and Etta Rae Brener, R.N., B.S.N., M.Ed. About 275 pp. Illustd. About \$10.05. Just Ready. Order no. 4528.

#### Spencer: Patient Care in Endocrine Problems

A comprehensive, clinically oriented text for nursing care in diseases and disorders of the endocrine system. Reviews physiology and pathophysiology of each endocrine organ and discusses diseases affecting the organ, their treatment and nursing care. By Roberta T. Spencer, R.N., M.S.N.E. 230 pp. Illustd.\$10.05. January 1973. Order no. 8517.

#### Dolan: Nursing in Society

A Historical Perspective - 13th Edition

From the "magic" of the witch doctor to the miracles of modern surgery, this new edition traces the influence of religion, medicine and the biological sciences on the nurse and her profession. By Josephine A. Dolan, R.N., M.S. 344 pp. 269 ills. \$9.30. April 1973. Order no. 3132.

#### Dienhart: Basic Human Anatomy and Physiology— 2nd Edition

This authoritative text offers increased coverage of the basic principles of the structure and function of the human body. By Charlotte Dienhart, Ph.D. 280 pp. 160 ills. 16 plates in full-color. \$5.10. July 1973. Order no. 3081.

#### Sloane: The Medical Word Book

For the nurse who manages an office—handles transcription—fills in insurance forms—here's a book that can be of help to you: a compendium of commonly used uncommon medical terms. Ideal for finding correct spellings in a hurry. By Sheila B. Sloane, President, Medi-Phone, Inc. 923 pp. Soft Cover. \$9.80. February 1973. Order no. 8364.

#### Frobisher & Fuerst: Microbiology in Health and Disease—13th Edition

Offers a firm understanding of the role microbiology plays in health care, and specifically shows how to apply such knowledge to clinical situations. By Martin Frobisher, Sc.D., and Robert Fuerst, Ph.D. 664 pp. 259 iffs. \$11.35. June 1973. Order no. 3938.

#### Fuerst: Laboratory Manual and Workbook for Microbiology in Health and Disease—5th Edition

Ideally suited for Frobisher and Fuerst's text described above. Exercises range from microscopy, morphology, and staining to sterilization, sanitation, immunity and pathogenic organisms. By Robert Fuerst, Ph.D. 198 pp. Illustd. \$4.65. July 1973. Order no. 3942.

W. 833	B. SA Oxford S	UNDERS (Street, Toront	COMPAI to 18, Onta	NY CANADA, LT	D.
	☐ 7220 ☐ 6098 ☐ 1696 ☐ 1436	Please send and	☐ bill me ☐ 8591 ☐ 5045 ☐ 4131 ☐ 4528	☐ send postpaid—check end ☐ 8517 ☐ 3132 ☐ 3081 ☐ 8364	losed □ 3938 □ 3942
Name				Address Prov	Zone CN 11-73

#### books

and equipment are rather antiquated. f am not certain that all of it is available in Canada, although I am aware that

One appliance, in particular, which is described, is rather large and bulky. As far as the irrigation for a colostomy is concerned, the equipment in Canada is more up-to-date. We do have kits

available that can be folded down for easy storage and packing for travel, as opposed to the large enema cans.

With the advent of enterostomal therapists in Canada, colostomy care is improving; new equipment and appliances are being made available for patients.

Essentials of Abdominal Ostomy Care is a handy reference book for staff nurses who are involved with the care of ostomy patients of any kind. It contains a chapter on anatomy and physiology, and also a chapter on

general information about stomas and appliances, with instructions for applying and cleaning the postoperative bag, care of excoriated skin, and application of permanent ostomy bags.

The ileostomy chapter gives specific postoperative care, and instruction for ileostomy lavage. The chapter on cecostomies includes the care of both the tube cecostomy and the tubeless cecostomy.

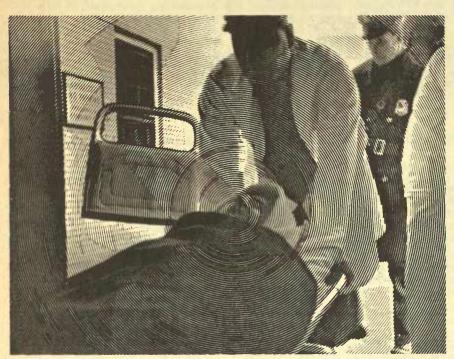
Care of the many types of colostomy (transverse, double barrel, loop, descending, sigmoid, and wet) are included, as well as irrigations and dilatation.

Urinary diversions are included in another chapter with care of the ileal conduit, eutaneous ureterostomy, and cystostomy.

Each section has a few questions to answer, and the book also includes diets for colostomy and ileostomy patients, a definition of terms, and refer-

All in all, this is an ideal book for every nursing station.

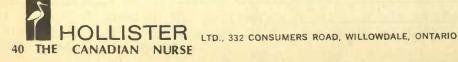
# EMERGENCY



## make no mistake about it!

Another patient is rushed into the emergency room, but even before diagnosis and treatment he must be identified or assigned a number. The reason is obvious and compelling: the right treatment must be given to the right patient...even if he is unconscious, confused, or unable to speak.

Hospitals throughout the United States are solving this real problem with a proven method of identification: Emergency Room Ident-A-Band by Hollister. Takes only seconds to apply to the wrist of each emergency patient. Hospital number and name (if known) are hand lettered right on the band. No insert card is required. Its distinctive color singles out the emergency patient from all others.



#### accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Materials on this list, except reference items, may be borrowed by CNA members, schools of nursing and other institutions. Reference (R) items (archive books and directories, almanaes and similar basic books) do not go out on Ioan. Theses (also R) are on Reserve and may go out on Interlibrary loan only.

Request for loans should be made on the "Request Form for Accession List" and should be addressed to: The Library, Canadian Nurses' Association, 50 The Driveway, Ottawa, K2P 1E2.

No more than three titles should be requested at any one time.

#### BOOKS AND DOCUMENTS

- 1. Activité de l'OMS en 1972. Rapport annuel du Directeur général à l'Assemblée mondiale de la Santé et aux Nations Unies. Genève. Organisation mondiale de la Santé. 1973. 342p.
- 2. Arithmetic for nurses: programmed for class use and home study, by Marilyn Ferster (Gilbert) 2ed. New York. Springer. 1973.
- 3. Basic microbiology, by Wesley A. Volk and Margaret F. Wheeler, 3ed, Toronto, Lippincott. 1973. 592p.
- 4. Blakiston's pocket medical dictionary, 3ed. Toronto, McGraw-Hill, 1973, 964p.
- 5. Building a national health-care system;

a statement on national policy, by Committee for Economic Development, Research and Policy Committee, New York 1973, 105p.

6. Catalogue de l'exposition commemorative du tricentenaire de la mort de Jeanne Mance, fondatrice de l'Hôtel-Dieu de Montréal, 1673-1973, par Marlène Gagnon et al. Montréal. Archives des Hospitalières de Saint-Joseph. 1973, 112p.

7. Centres d'information communautaires; formule pour le Canada des années 70. Etude réalisée pour le gouvernement canadien. Ottawa, The Public Policy Concern, 1971. 70p.

8. A current perspective on accreditation, by Frank G. Dickey and Jerry W. Miller. Washington, D.C., American Association for Higher Education, 1972, 68p.

9. Des médecius et des hommes, par Guy Godlewski. Paris, L'Expansion, 1972, 389p.

10. Dictionnaire des sciences de la gestion, par Henri Tézenas Du Montcel. Paris. Mame, 1972, 331p.

11. La diététique dans la vie quotidienne; bien manger, boilne santé, par Louise Lambert-Lagacé. Montréal. Editions de l'Homme. 1973, 152 p.

12. Drug dependence other than alcoholism; practical guide to diagnosis and treatment. 2ed. Montreal. College of Physicians and Surgeons of the Province of Quebec. 1973. 68p.

13. Emergency medical guide, by John Henderson. 3ed. Toronto. McGraw-Hill, 1973. 651p.

14. Handbook for camp nurses and other camp health workers, by Mary Lou Hamessley, New York, Tiresias Press, 1973, 159p.

15. Health sciences education. Toronto, Mediascience Ltd., 1973, 1 vol.

16. Hospital legislation and hospital systems, by R.F. Bridgman and M.T. Roemer. Geneva, World Health Organization, 1973, 233p. (World Health Organization, Public health papers no. 50)

17. The human body; a survey of structure

had ugly superfluous hair...was

unloved...discouraged. Tried many things...even razors. Nothing was

satisfactory. Then I developed a sim-

ple, painless, inexpensive, nonelectric

method. It has helped thousands win

beauty, love, happiness. My FREE

book, "What I Did About Super-

Nuous Hair" explains method. Mailed

in plain envelope. Also Trial Offer.

Write Mme Annette Lanzette, P.O.

Box 610, Dept. C-376, Adelaide St.

NOW HAPPY! 1

and function, by J. Cairney and John Cairney, 2ed, Christchurch, New Zealand, Peryer, 1973, 289p.

18. Improving languagh skills; a study guide for prospective health workers, by Esther Zimmerman. New York, Springer, 1973, 221p.

19. Intensive nursing care by Lenette Owens Burrell and Zeb L. Burrell. 2ed. St. Louis. Mosby, 1973, 360p.

20. Interrelationships between health programmes and socio-economic development. Geneva, World Health Organization, 1973. 54p. (World Health Organization, Public health papers no. 49)

21. Introduction to nursing by May Spencer and Katherine M. Tait. 3ed. London, Blackwell Scientific Pub. 1973, 515p.

22. The law and mental disorder, by Barry B. Swadron and Donald R. Sullivan. Rev. Toronto. Canadian Mental Health Association, 1973, 186p.

23. Manual of respiratory therapy, by Clifford D. Bryan and Joan P. Taylor. St. Louis. Mosby, 1973, 129p.

24. Medical engineering; projections for health care delivery, by Robert Frazer Rushmer. New York, Academic, 1972, 391p.

25. The nurses' aide, by Charlotte Isler. 2ed. New York, Springer, 1973, 153p.

26. Nursing in society; a historical perspective, by Josephine A. Dalan, 13ed, Philadelphia, Saunders, 1973, 344p.

27. Nursing social, par Ruth B. Freeman. Montreal, Les Editions HRW Ltée, 1973. 464p.

28. An overview of pacing; a quick look at the principles, technical and medical, of artificial heart pacing, by William Jakoki. Minneapolis, Minn., Medtronic, 1973, Ivol.

29. The patient at home; a manual of exercise programs, self-help devices and home care procedures, by Marylou R. Barnes and Carolyn A. Crutchfield. Thorofare, N.J., Slack, 1971, 187p.

30. Le plan de soins, par C. Mordacq et al. Paris. Comité d'entente des écoles d'infirmières et des écoles de cadres, 1970, 54p.

31. Planning the special library; a project of the New Yrok Chapter, SLA. Edited by Ellis Mount. New York, Special Libraries Association, 1972, 122p.

32. Profile du stage en déficience mentale, par Nicole Ward, Hull, P.Q., 1973. I vol.

33. Psychiatric nursing, by Annie Therese Altschul, 4ed, London, Baillière Tindall, 1973, 390p.

34. Publications, films, slides, exhibits. Newark, N.J., CIBA Educational Services, 1973, 24p.

35. Readings in family planning; a challenge to the health professions, by Donald V. Mc-Calister et al. St. Louis, Mosby, 1973, 256p.

36. Respiratory nursing care; physiology and technique, by Jacqueline F. Wade. St. Louis, Mosby, 1973, 171p.

37. Reuse of effluents; methods of wastewater treatment and health safeguards; report of a WHO Meeting of Experts. Geneva, World Health Organization, 1973, 63p. (Its Technical report series, no. 517)



This hand was bandaged in just 34 seconds with

## Tubegauz

SEAMLESS TUBULAR GAUZE

It would normally take over 2 minutes. But the Tubegauz method is 5 times faster—10 times faster on some bandaging jobs. And it's much more economical.

Many hospitals, schools and clinics are saving up to 50% on bandaging costs by using Tubegauz instead of ordinary techniques. Special easy-to-use applicators simplify every type of bandaging, and give greater patient comfort. And Tubegauz can be autoclaved. It is made of double-bleached, highest quality cotton. Investigate for yourself. Send today for our free 32-page illustrated booklet.

Surgical Supply Division	
Scholl (Canada) Inc.	
174 Bartley Drive, Toronto 16, Onta-	ric

Please send me "New Techniques of Bandaging with Tubegauz".

NAME ADDRESS

SCHOLL (CANADA) INC

69H9

P.O., Toronto 210, Ont.

#### Next Month in

#### The Canadian Nurse

- Independence for Phocomelic Children
- Myasthenia Gravis
- Clinical Laboratory Procedures



#### Photo Credits for November 1973

Nord Photo, Ste-Adèle, Quebec, p. 7

Kingston General Hospital, Kingston, Ontario, pp.18-20

#### accession list

38. The clinical nurse specialist: interpretations, edited by Joan P. Riehl and Joan Wilcox McVay. New York, Appleton-Century-Crofts, 1973. 507p.

39. School intervention. Edited by William L. Claiborn and Robert Cohen. New York, Behavioral, 1973. 265p. (Community-clinical psychology, v.1)

40. Short courses and seminars. Willowdale, Ont., Development Publications, 1973. 64p. R 41. Soins infirmiers en maternité, par Elise Fitzpatrick et al. Montreal, Editions du Renouveau Pédagogique, 1973. 476p.

42. The surgical patient; behavioral concepts for the operating room nurse, by Barbara J. Gruendemann et al. St. Louis, Mosby, 1973. 152p.

43. Teen health manual; a manual for young people. 5ed. Toronto, Canadian Red Cross Society, 1972. 96p.

44. Terminologie du traitement de l'information. 4éd. Paris, International Business Machines Corporation, 1972. I vol. R

45. Tout se joue avant six ans, par Fitzhugh Dodson. Traduit de l'américain par Yvan Geffray. Paris, Robert Laffont, 1972, 430p. 46. The work of Mrs. Bedford Fenwick and the rise of professional nursing, by Winifred Hector. London, Royal College of Nursing and National Council of Nurses of the United Kingdom, 1973, 85p.

47. Workbook for the nurses' aide, by Charlotte Isler, New York, Springer, 1973, 71p.

#### PAMPHLETS

48, Ambulatory care, by Fernande P. Harrison. Monticello, Ill., Council of Planning Librarians, 1973. 17p. (Council of Planning Librarians. Exchange bibliography 386)

49. Articles of incorporation and bylaws, amended to Oct. 1970. Louisville, Kentucky Nurses' Association, 1970. 36p.

50. Articles of incorporation, purposes, philosophy, state bylaws, standing rules. San Francisco, California Nurses' Association, 1971, 47p.

51. A brochure, short history and manual report, Kampala, Uganda, Uganda Nurses, Medicins and Nursing Assistants Council, 1971, 28p.

52. Bylaws as amended, Oct. 8, 1971. Chicago, Illinois Nurses' Association, 1971. 59p.

53. Bylaws 1973. Harrisburg, Penna., Pennsylvania Nurses' Association, 1973.

54. Bylaws. Rev. April 1971. Denver, Col., Colorado Nurses' Association, 1971. 20p.

55. Care of the aging and aged; a resource unit for instructors in medical-surgical nursing, by Marjorie Berger et al. New York, National League for Nursing, 1959, 26p. (League exchange no. 34)

56. Cinq années d'activité de l'Escola de Ensino e Administração de enfermagem, par Mariana Dulce Diniz de Sousa. Lisbon, 1973, 16p.

57. Colostomies; a guide, by Edith Lennesberg and Alan N. Mendelssohse. Los Angeles, United Ostomy Association, 1969, 31p. 58. Data and statistics on nursing in Japan. Tokyo, International Nursing Foundation of Japan, 1973, 40p.

59. Dimensions of staffing patterns; a guide for patient care based on research and pilot projects, by Geraldine T. Hall. Cleveland, Ohio, Paul Scott, 1972. 32p.

60. Duties and responsibilities of directors in Canada, by J.M. Wainberg, 2ed. Don Mills, Ont., CCH Canadian Ltd., 1972. 61, Five years activity in the nurses training and management school, by Mariana Dulce Diniz de Sousa. Lisbon, 1972. 8p.

62. Health vare consultation: a bibliography, by Fernande P. Harrison, Monticello, Ill., Council of Planning Librarians, 1973, 15p. (Council of Planning Librarians, Exchange bibliography 370)

63. Hospital merger; a bibliography, by Fernande P. Harrison. Monticello, Ill., Council of Planning Librarians, 1973. 5p. (Council of Planning Librarians. Exchange bibliography 371)

64. Nursing practice I/S. San Francisco, California Nurses' Association, 1971. 19p.

65. Planning health care facilities: a bibliography, by Fernande P. Harrison. Monticello. Ill., Council of Planning Librarians. 1973. 13p. (Council of Planning Librarians. Exchange bibliography 369)

66. Position paper on nursing practice. Vancouver, Registered Nurses' Association of British Columbia, 1973, 9p.

67. Proposed revisions to Missouri State Board of Nursing Chapter 335. Jefferson City, Mo., Missouri State Nurses' Association, 1973. 26p.

68. Public Affairs Committee, New York, 1973. Pamphlets.

no. 492 Securing the legal rights of retarded persons, by Elizabeth Ogg. 28p.

no. 493 When people need help, by Maxwell S. Stewart. 23p.

no. 494 The campaign for cleaner air, by Marvin Zeldin. 28p.

69. Une question de poids...quelques conseils et suggestions. Toronto, General Foods, Ltée, n.d. 25p.

70. Recent developments in genetics, by Richard Roblin. Baltimore, Md., Theological Studies, vol. 33, 1972. 23cm.

71. Report on a survey of CCU design, staffing, and operating policies, by M.A. Rockwell. Santa Monica, Calif., Rand Corporation, 1970. 14p.

72. Spotlight on shopwindow staff; a hospital manager's checklist, compiled by M. Dorothy Hinks. London, King Edward's Hospital Fund for London, 1973. I vol.

73. Urinary ostomies: a guidebook for patients, by Katherine F. Jeter. Los Angeles. United Ostomy Association, 1972, 31p.

74. Witches, midwives, and nurses; a history of women healers, by Barbara Ehrench and Deidre English. 2ed. Old Westbury, N.Y., Feminist Press, 1973, 45p.

GOVERNMENT DOCUMENTS

Australio

75. Committee on Overseas Professional Qualifications. Nursing in Australia. Canberra, 1972, 18p.

California

76. Dept. of Consumer Affairs. Laws relating to nursing education, licensure, practice with rules and regulations issued by Board of Nursing Education and Nurse Registration. Sacramento, Calif., 1972, 53p.

Canada

77. Conseil des sciences du Canada. Les associations nationales d'ingénieurs, de scientifiques et de technologues du Canada. Vues d'avenir et recommundation du Comité de directions de SCITEC, by Allen S. West. Ottawa, Information Canada, 1973. 134p. (Its Etudes spéciale no. 25)

78. - L'innovation et la structure de l'industrie canadienne, par Pierre L. Bourgault. Ottawa, Information Canada, 1973. 135p. (Its Etude spéciale no. 23)

79, Dept. of National Health and Welfare. Health Protection Branch. Educational Services. Selected teaching nutrition aids for public health nurses. Ottawa, Information Canada, 1973. 70p.

80. Dominion Bureau of Statistics. Econometric study of incomes of Canadian families 1967. Ottawa, Information Canada, 1972.

81, —. Family incomes (Census families)

1967. Ottawa, Information Canada, 1972.

82. —. Population projections by provinces: 1969-84. Ottawa, 1970. 2p.

83. —. Socio-economic characteristics of the population age 14 to 24, 1967. Ottawa, Information Canada, 1972, 67p.

84. Environment Canada. Public health professionals and the environment: A study of perceptions and attitudes, by J. Elizabeth McMeiken. Ottawa, Information Canada, 1972. 117p. (Social Science series no. 5)

85. Health and Welfare Canada, Health services in Canada. Ottawa, 1973? 53p.

86. -. Task Force on Community Health Auxiliaries. Community health auxiliaries; report, Ottawa, 1973. 190p.

87. Ministry of State for Science and Technology. Report, 1971/72. Ottawa, 1973, 22p.

88. National Science Library. Directory of Canadian scientific and technical periodicals; a guide to currently published titles. 5ed. Ottawa, 1973. 49p. R

89. Prices and Incomes Commission. Feesetting by independent practitioners; a study prepared for the Prices and Incomes Commission, by John Crispo. Ottawa, Information Canada, 1972. 33p.

90. Santé et Bien-être social Canada. Immunisation; guide du voyageur international. Ottawa, Information Canada, 1972. 31p.

91. Science Council of Canada. Education and jobs, by A.D. Boyd and A.C. Gross.

Ottawa. Information Canada, 1973. 139p. (Its Special study no. 28)

92. —. Essays on aspects of resource policy by W.D. Bennett et al. Ottawa, Information Canada, 1973, 113p. (Its Special study no. 27) 93. - Governments and innovation, by Andrew H. Wilson. Ottawa, Information Canada, 1973. 275p. (Its Special study no. 26)

94. —. Report 1972-73. Ottawa. Information Canada, 1973. 48p.

95. Statistics Canada. Canadian statistical review: historical summary 1970, Ottawa. Information Canada, 1972, 148p.

96. —. Population Estimates and Projections Section. Interim population projections for 1971-2001. Ottawa, 1972. 16p.

97. —. Suicide mortality, 1950-1968. Ottawa. Information Canada, 1972, 62p.

Colorado

98. Laws, statutes, etc. Professional nursing practice act enacted March 26, 1957, as amended. Reprinted April 1967. 16p. Illinois

99. Dept. of Registration and Education. The Illinois nursing act. Springfield, Ill., 1971. 27p.

Kentucky

100. Laws, statutes, etc. Nursing law 1966. Louisville, Legislative Research Commission, 1966. 19p.

New Zealand

101. Dept. of Education. Nursing education in New Zealand. Wellington, 1972. 28p.

New, from HR&W ...

#### CONTEMPORARY ISSUES IN **CANADIAN LAW FOR NURSES**

by

Shirley R. Good Janet C. Kerr

- the only book currently available that provides a comprehensive coverage of the legal scene as it applies to the nursing profession in Canada today
- ideal for diploma or degree students and as a ready reference for practising nurses in all fields
- available in English and French editions

Price: \$6.95 (tentative)

Other Canadian titles from HR&W:

K. Ishwaran, THE CANADIAN FAMILY: A BOOK OF READINGS, John J. Mitchell, HUMAN LIFE: THE FIRST TEN YEARS,

John J. Mitchell, ADOLESCENCE: SOME CRITICAL ISSUES.

John J. Mitchell, HUMAN LIFE: THE EARLY ADOLESCENT YEARS,

\$ 4.30 Paperback

\$ 7.90 Hardbound

\$ 3.35

\$ 3.95 (Tentative)

To be available January, 1974

For further information, write to:

#### HOLT, RINEHART AND WINSTON OF CANADA LIMITED

55 Horner Avenue, Toronto, Ontario M8Z 4X6

#### accession list

#### Ontario

102. Ministry of Correctional Services. Enquiry into the health care system in the Ministry of Correctional Services. Report to the Minister, by E.H. Botterell, Committee of One. Toronto, 1972, 435p.

103. Ministry of Labour. Employee use of advance notice of terminiation for job search, by H. Stiekert. Toronto, 1973. 18p. (Employment information series no. 2)

104. — Employment trends in Ontario 1961-1972. Toronto, 1973. 34p. (Employment information series no. 1)

105.—Selected characteristics of compressed work schedules in Ontario. Toronto, 1973. 17p. (Employment information series no. 3)

#### Quebec

106. Ministère des Affaires municipales. Services de l'Information. Dossier: la presse écrite face à l'environnement. Québec (ville) 1971, 200p.

107. Ministère des Affaires sociales. Normes des garderies de jour. Québec, 1972. 18p. United States

108. Dept. of Health, Education, and Welfare. Health Services and Mental Health

Administration. Maternal and Child Health Service. Promoting the health of mothers and children, fy 1972. Washington, D.C., U.S. Govt. Print. Off., 1972. 107p.

109. National Center for Health Services Research and Development. Experimental Medical Care Review Organization (EMCRO) programs, by Barry Decker et al. Cambridge, Mass., 1973. 196p. DHEW Publication no. (HSM) 73-3017)

110. National Institutes of Health. Nurse staffing methodology; a review and critique of selected literature, by Myrtle K. Aydelotte. Bethesda, Md., 1973. 538p. (DHEW Publication no. (NIH) 73-433)

#### STUDIES DEPOSITED IN CNA REPOSITORY COLLECTION

111. Facteurs associés au manque d'assiduité du client à la clinique externe génito-urinaire à l'hôpital pédiatrique, par Madeleine Clément. Montreal, 1972. 92p. (Thèse (M. Nurs.) — Montreal) R

Library Loan Service

As usual, mailing of material on loan for the library will be curtailed over the holiday mailing season. Loans will not be mailed out, therefore, between December 3, 1973 and January 4, 1974

112. Health manpower output of Canadian education institutions, by H. Rocke Robertson, J.F. Houwing, and L.F. Michaud. Ottawa, Association of Universities and Colleges of Canada, 1973, 180p, R

113. Nurse manpower study in the province of British Columbia, 1968, by Eva M. Williamson, Eleanor S. Graham and Roberta J. Cunningham. Vancouver, British Columbia Health Resources Council, 1970, 88p. R

114. A study of the attitudes of public health nurses as they affect the teaching of family planning, by Ada E. McEwen. Chapel Hill, N.C., 1972. 72p. (Thesis (M.P.H.) — North Carolina) R

#### ARTIFACTS

115. Student uniform, 1966. Memorial University, School of Nursing, St. John's, Nfld. Green and white striped dress, white apron with bib; student caps, street and duty; gradnate cap and pin. Donated by Miss Joyce Nevitt, first director of the school.

#### AUDIOVISUAL AIDS

116. Emergency department nursing; programmed learning. Demonstration cassette. New York, American Journal of Nursing Co., Educational Services Division, 1972. 1 tape cassette.

117. Sonomed, série 1 no. 1-6. Montreal, Association des Médecins de Langue française du Canada, 1973. 6 cassettes.

#### Request Form for "Accession List"

#### CANADIAN NURSES' ASSOCIATION LIBRARY

Send this coupon or facsimile to: LIBRARIAN, Canadian Nurses' Association, 50 The Driveway, Ottawa, Ontario. K2P 1E2. Please lend me the following publications, listed in the ....................... issue of The Canadian Nurse, or add my name to the waiting list to receive them when available: Item Author Short title (for identification) No. ...... ..... Requests for loans will be filled in order of receipt. Reference and restricted material must be used in the CNA library. Borrower Registration No.

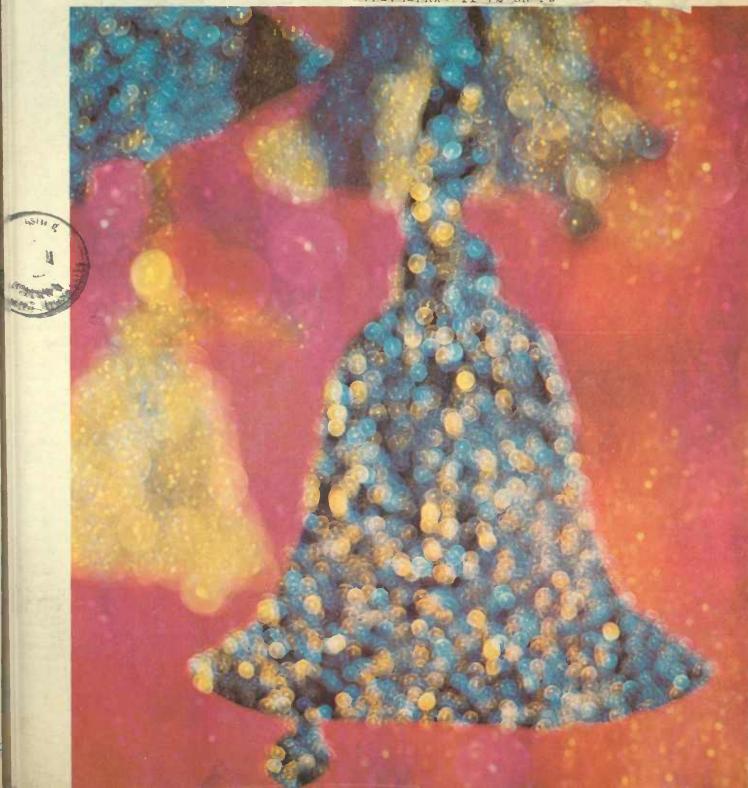
DO NOT TAKE OUT OF LIBRARY

# The OUT OF LISE Canacian School of NU UNIVERSITY OUT OUT AWA, ONT KIK 072 12.73-FAX--

December 1973

SCHOOL OF NURSING LIBRARY UNIVERSITY OF OTTAWA

12-73-FAX--11-72-CN-PD



# Lippincott audio visual media





## A LIPPINCOTT LEARNING SYSTEM

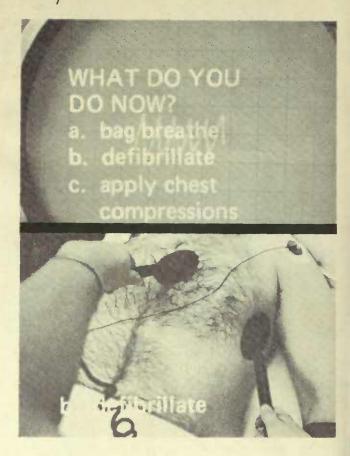
45

A multimedia, self-instruction program in the principles, basic procedures and manual skills fundamental to patient care.

Developed and programmed by the University of Wisconsin-Milwaukee School of Nursing. Project Director, Elizabeth A. Krueger, R.N., Ed.D.

The LLS program consists of: Color 35mm filmstrips and synchronized audio cassettes that present cognitive and motor skills in step-by-step sequence, with multiple-choice reinforcement; Student Guide/Workbooks that include lists of prerequisites, behavioral objectives, instructions, required practice materials, and exercises; Teacher's Guides that include diagnostic tests, synopses, written tests and answers, motor performance tests. Required equipment: Any automatic 35mm filmstrip projector, and a special cassette player (Educassette) designed for multiple-choice response.

Available LLS units: Anatomical Terminology and Joint Classification. Management of the Environment. Body Mechanics. Making a Bed. Vital Signs. Care of the Mouth. Bowel Elimination. Care of the Skin. Oral Medication. Parenteral Medication. Range of Motion. Management of the Environment: Medical and Surgical Asepsis.



#### **DECISION MEDIA**

Life-threatening patient problems requiring immediate nursing assessment and action.

This series of 35mm audio filmstrips, in color, covers critical situations where immediate recognition of problems and appropriate intervention are essential. Each film pauses at crucial decision points, asks a question, and allows time for the student to analyze the problem and make a decision before the film proceeds. Each situation stimulates reaction and logical thinking. The student becomes involved and motivated; learning becomes a dynamic experience—so does teaching!

#### Critical areas covered include:

Cardiac Care: Gives the student or graduate an opportunity to apply knowledge of coronary care in situations where life-threatening arrhythmias must be anticipated and managed.

Respiratory Care: Provides the nurse or therapist with a basic understanding of what is involved in caring for the tracheostomy patient. She learns how to react to crisis and maintain respiration while she looks for the cause of the problem.

Neurological Care: Teaches the student or graduate how to recognize, assess, and react to complications that occur with the neurological patient.

Post-Surgical Care: Enables the student to better understand postoperative care. She learns what it is like to care for the unconsclous patient and how to prevent normal post-operative episodes from becoming serious.

Instructor's Guides and Student guides are included.

Decision Media films are compatible with most existing filmstrip projection equipment. Please write for further information.

# meet a variety of learning needs



#### **HUMAN BIRTH FILMS**

In dramatic live action . . . close-up, full-color (sound or silent) films of deliveries which students rarely have the opportunity to see in the course of their clinical experience.

Six film sequences demonstrate: Vertex Delivery, with Forceps. Vertex Delivery, Spontaneous. Breech Delivery, Assisted. Breech Delivery, with Forceps. Breech Delivery, Extraction. Cesarean Delivery.

Available on six separate Super-8mm film loops (sound or silent), or on one 16mm sound film showing all presentations.

#### Available in SOUND and SILENT films as follows:

- Super-8mm optical or magnetic SOUND on reels or in Kodak\* Cartridge ......\$32.00
- Super-8mm SILENT—with superimposed titles—on reels or in either Technicolor or Kodak Cartridge \$25.00
- 16mm SOUND—All birth presentations in one film \$285.00

\*Super-8mm SOUND films can be cartridged for Technicolor, Fairchild or other projectors at \$32.00 per tille, plus cost of cartridge. Please write for price quotation, giving make and model of projector to be used.



## LIPPINCOTT SUPER-8MM FILM LOOPS (Silent)

Procedures in Patient Care: Wound Care (8 loops). Urinary Catheterization and Care (9 loops). Injection Technic (9 loops). Drainage, Suction, Irrigation: Pulmonary and Gastric (15 loops). Lifting and Moving Patients (6 loops). Positioning and Exercise (3 loops). Hygiene (3 loops). Asepsis: Medical and Surgical (9 loops). Bedmaking (6 loops) Each Film Loop: \$21.50 Lippincott film loops can be displayed with the Technicolor Super/8 Movie Projector, or with similar projectors.

For additional information on LLS, Decision Media, Human Birth Films, or Lippincott Film Loops, please write:



J. B. Lippincott Company of Canada Ltd. 75 Horner Avenue, Toronto, Ontario M8Z 4X7 (416) 252-5277

Serving the health professions in Canada since 1897



For a complimentary pair of white shoelaces, folder showing all the smart Clinic styles, and list of stores selling them, write:

THE CLINIC SHOEMAKERS • Dept. CN-12, 7912 Bonhomme Ave. • St. Louis, Mo. 63105

# The Canadian Nurse



A monthly journal for the nurses of Canada published in English and French editions by the Canadian Nurses' Association

Volume 69, Number 12

December 1973

- 25 The Pandemic Influenza of 1918 ...... G. Morton

I-XXIV 1973 Index

The views expressed in the editorial and various articles are those of the authors and do not necessarily represent the policies or views of the Canadian Nurses' Association.

4 Letters

44 New Products

7 News

- 47 Dates
- 40 In a Capsule
- 48 Books

41 Names

51 Accession List

Executive Director: Helen K. Mussallem • Editor: Virginia A. Lindabury • Assistant Editors: Liv-Ellen Lockeberg, Dorothy S. Starr • Editorial Assistant: Carol A. Dworkin • Production Assistant: Elizabeth A. Stanton • Circulation Manager: Beryl Darling • Advertising Manager: Georgina Clarke • Subscription Rates: Canada: one year, \$6.00; two years, \$11.00. Foreign: one year, \$6.50; two years, \$12.00. Single copies: \$1.00 each. Make cheques or money orders payable to the Canadian Nurses' Association. • Change of Address: Six weeks' notice; the old address as well as the new are necessary, together with registration number in a provincial nurses' association, where applicable. Not responsible for journals lost in mail due to errors in address.

Manuscript Information: "The Canadian Nurse" welcomes unsolicited articles. All manuscripts should be typed, double-spaced, on one side of unruled paper leaving wide margins. Manuscripts are accepted for review for exclusive publication. The editor reserves the right to make the usual editorial changes. Photographs (glossy prints) and graphs and diagrams (drawn in india ink on white paper) are welcomed with such articles. The editor is not committed to publish all articles sent, nor to indicate definite dates of publication.

Postage paid in cash at third class rate MONTREAL, P.O. Permit No. 10,001, 50 The Driveway, Ottawa, Ontario, K2P 1E2

Canadian Nurses' Association 1973.

SEASONS

### letters

Letters to the editor are welcome.

Only signed letters will be considered for publication, but name will be withheld at the writer's request.

Patient care committee needed

My sincere thanks to Margaret Guthrie for describing her alarming experiences in "Cardiac surgery in the first person"

(Sept. 1973, p. 31).

Her article confirms what many of us fear to admit: technological progress in medicine and surgery is not necessarily accompanied by improved humane care. In fact, the opposite may be true.

There is, indeed, much more to nursing than "running machines and passing out pills." And, if nurses are not concerned with the welfare of the whole patient, it is safe to assume no

one else will be.

That Ms. Guthrie, herself a nurse, should endure such indignities in a famous teaching hospital surely indicates the need for radical changes. As professionals, let us admit that standards of patient care have deteriorated, and that we are obliged ethically to do

something about it.

A suggestion that concerned colleagues might consider is the formation in every accredited hospital of "quality of patient care committees." Rather like "tissue" committees and similar devices for monitoring professional practices, these committees would have the following functions: 1. defining acceptable standards; 2. actively seeking the assistance of patients and relatives to assess the quality of care provided; and 3. alerting hospital administration when standards are in danger of falling below acceptable levels.

If the situation is not improved after negotiation, our professional association should be informed. Appropriate action may then be taken either to remedy the matter or to sanction the withdrawal of nurses, since to continue would constitute a form of unethical practice.

Jane Greenland, R.N., Toronto,

Ontario.

Cardiac nurses respond

The prolonged extent of physical and emotional trauma experienced by Margaret Guthrie, as expressed in her article "Cardiac surgery in the first person" (September 1973), is as obvious and tragic as the fact that the nurses and doctors caring for her neither cared about nor met her personal needs.

As nurses who are part of a cardiac

surgical unit, which certainly is not like the one Ms. Guthrie described, we believe we must object strenuously to some of the generalizations made in the article. One person could not, and should not, write "everyone's story."

From the 900 patients operated on for a wide variety of cardiac ailments, most of the feedback we receive is positive. Many visit or write on the

"anniversary" of their surgery.

We would be interested in knowing precisely what surgery Ms. Guthrie underwent (mitral split? valve replacement?), as this might have affected her postoperative course. Whatever the surgery, however, one would have expected the patient to consider it as a positive step, rather than a continuation of the denial that a heart problem existed, for it should be the key to a healthier, happier future.

All patients in our unit are seen and taught preoperatively by a nurse clinician, an inhalation therapist, and a social worker, and are seen by their surgeon and anesthetist. Most patients do not consider cardiologists as "saints"

and surgeons as "satans."

Our patients are strongly advised not to smoke, on the basis of research concerning the effect of nicotine on the coronary arteries, and on the direct proportion of postoperative chest complications experienced by smokers.

The statement in the article that one chain smoker "sailed through surgery" (no mention is made of what kind of surgery), while his quiet, non-smoking roommate "diet of infection" shows an embarrassing naïveté when written by an educated nurse.

Ms. Guthrie's unfortunate experience must shame any nurse involved. It is particularly distressing because, after two years, many cardiac surgery patients have forgotten most of the in-

herently traumatic details.

In any well-planned surgical unit, Ms. Guthrie's conclusions are a fact. We sincerely regret her experience, but know it is not typical. For this reason, we have made our views known.

#### Letters Welcome

Letters to the editor are welcome. Because of space limitation, writers are asked to restrict their letters to a maximum of 350 words.

Diane Stephenson, on behalf of the nurses of the cardiac surgery team, Ottawa Civic Hospital, Ottawa, Ont.

Author replies

I regret that the nurses of the cardiac surgery team at the Ottawa Civic Hospital believed that I was condemning all units involved in this surgery in the country, or that I was speaking for all heart surgery patients. I was speaking for five patients with similar backgrounds in age, education, occupation, and community responsibilities.

l bear no animosity toward cardiac nurses. This personal case study could speak for events that have occurred in all types of nursing units. For years, good nurses have condoned poor quality care by not speaking out against it,

let alone writing about it.

The surgery I underwent was a mitral split — a piece of cake in cardiology. As for the other patients, two had mitral valve replacements and three had by-

pass grafts.

I am surprised you failed to pick up the unspoken point of the anecdote about the roommates who had bypass grafts. This was an example of Dr. Hans Selye's theory of stress. Patients look for ways to lessen their level of anxiety. If they are unable to do this, the resistance of their body to infection and to the surgery itself is lowered.

The range of emotions described

The range of emotions described from a patient's point of view was intended first to be educational, and then critical. I have bared my innermost thoughts throughout a crisis situation. Failing to recognize the commonality of responses indicates lack of knowledge

of psychology.

I am not surprised that a well-planned unit exists, where poor quality care is the exception, not the rule. If I believed that attaining this level was impossible, I could not stay in nursing. I have had too many role models, like the director I mentioned, to throw in the sponge. I am also not so naive to acknowledge that the cardiac unit at the Ottawa Civic is typical. — Margaret Guthrie.

#### Nurses should not retire

The long-retired nurse who wishes to get back into active duty in a general hospital seems to be in a sorry plight.

DECEMBER 1973

She might get a chance to work in a general hospital if she has been out of nursing for more than five years, but the changes she will find will be surprising.

Those who have been out of nursing for 10 years or more will be amazed by the changes. Nurses are now calculating the rate of flow in intravenous infusions to allow a specified number of cc. in a given time, whereas older nurses will remember their instructions not to tamper with the rate of flow, but to keep the drip constant as set. There are crash carts and emergency carts set up to handle disasters such as cardiac arrest, whereas there was no cardio-pulmonary resuscitation 18 years ago.

In Ontario, there is no available retraining course. The lectures that were given by the Registered Nurses' Association of Ontario, in conjunction with the provincial government, have not been available since 1965. Now there does not seem to be the shortage of nurses that plagued hospitals in the past. Gone are the days when a nurse was hurried from her interview to her duty area, with scarcely time to set her cap.

There seems to be no solution at present, unless nurses apply in great numbers to the community colleges for retraining programs. The colleges might not consider doing anything in this area unless a need is indicated. At the moment, a registered nurse returning to general duty after 10 or more years of retirement could, at best, offer to work at the registered nursing assistant level. This would seem to be a dead end, since RNAs have a limited range of responsibility.

It seems advisable that nurses never retire completely. One never knows which one of us will have to return to work some day. It would be good insurance for the married nurse to hire a housekeeper or baby-sitter and keep nursing, one or even two days a week. This would give a housewife time away from her chores and keep her up-to-date with changes in nursing. The salary would pay the expenses, and the companionship of other nurses would be stimulating.

We should never fully retire from nursing while our children are growing up. If we are not abreast of things when we want to go back, we are in a sorry plight indeed. — Mary P. White, Mississauga, Ontario.

#### Nurses penalize themselves

As a retired nurse in good standing with the Registered Nurses' Association of British Columbia, I have often wondered why we, as a group of intelligent women, penalize ourselves to the advan-

tage of our provincial governments.

We make agreements whereby a nonregistered nurse receives a salary \$100 less per month until she becomes registered in her province, although she gives the same patient service as registered nurses give. Would it not be more logical to have a provincial practicing fee, which would decrease after registration? It is our provincial association that evaluates the nurse's credentials.

— Vilda MacNeil, Victoria, British Columbia.

#### Nurse offers journals

I have a complete series of *The Canadian Nurse* from 1967 to the present, which I would like to give to a library in any school of nursing. The recipient should expect to pay the shipping charges. The journals are available only as a complete series and on a "first come" basis. — *Beverley Orieux*, *Box 597*, *Stony Plain*, *Alberta*.

#### Why is nursing divided?

The greatest concerns in Canada today are unity and equality, both being of equal importance.

Neither of these concerns are apparent in the nursing profession in Canada. We are not unified, as registration in one province is not a guarantee of registration in another province. Equality is even less evident; note the discrepancies in salaries, working conditions, job descriptions, responsibilities, and job security.

Why is the profession so divided? We have a national association. Has it ever tried to obtain national standards? Surely these are some of the concerns of members.

The fact that nurses in several provinces have resorted to strikes to obtain financial and job security must indicate that the nature of our profession is changing. We can no longer hide our heads in beautiful theories and ideals. We must get down to practicalities.

When is *The Canadian Nurse* going to realize this? When will we see articles published on labor relations, union negotiations, and other educational articles in this vein? This is becoming an essential aspect of our profession.

We can no longer think of ourselves as Florence Nightingales, living on government handouts. We must become nationally organized to protect our profession, increase its size, and provide better services. Improved nursing services depend as much on morale as on knowledge. All the theory in the world will not guarantee good services if nurses are discontented. — Susan Mullan, Reg.N., Burnaby, British Columbia.

# The least you can do for hospitalized diabetics

It's not that you should do more. It's just that KETO-DIASTIX\* Reagent Strips require the least amount of effort in testing for glucose and ketones in urine. Simply dip into urine and get a semiquantitative reading for glucose and ketones in 30 seconds. What could be easier and less troublesome for you and the patient? Useful all around the hospital. On wards, at the bedside, in patient teaching centers, and in the O.P.D. Also, a good test to recommend for the patient to use at home after discharge. Obtain full details on KETO-DIASTIX by calling your Ames Systems Specialist or by writing to the address below. It's the least work you can do in diabetic urine testina.

#### **Keto-Diastix**

Ames Company



Division Miles Laboratories, Ltd. 77 Belfield Road, Rexdale, Ontario

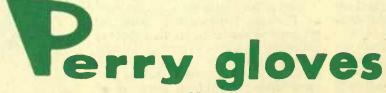
"Chemical and biological information systems serving Medicine and Industry"



Who makes surgeons' gloves for the giants of skill who are small in stature and wear size 51/2



Perry!...Naturallyl But why? —Because small in stature doesn't mean small in the appreciation of proper fit and other features and benefits that have made Perry the most widely used latex surgeons' gloves—in any size! Like all Perry Latex Surgeons' Gloves, size 5½s have beaded wrists for added protection and strength, whisper thin palms to lessen hand fatigue, exclusive Dermashield® process that provides a durable hypo-allergenic finish and packaging to fit your preferred dispensing technique. If you'd like a sample of Perry Latex Surgeons' Gloves, please write us. By the way, you don't have to wear size 5½, we'll send you the size gloves that fit you.



A PRODUCT OF
AFFILIATED MEDICAL PRODUCTS LIMITED
90 Commercial Ave., Ajax, Ontario

#### news

## **CNA And Provincial Associations** Support Federally Employed Nurses Who Protest Salaries Below Peers

Ottawa — The Canadian Nurses' Association, the registered nurses' associations of British Columbia and Alberta, the Manitoba Staff Nurses' Council, and the Nova Scotia Government Employees' Association, which includes nurses, have expressed support of federally employed nurses in their protest over an arbitration award that fails to give them financial parity with their provincial counterparts.

CNA sent a telegram to C.M. Drury, president of the treasury board; Minister of Health and Welfare Marc Lalonde; R. Val Scott, executive director of the Professional Institute of the Public Service of Canada; and Ruth Sear, chairman of the federal nurses of Canada.

The text of the CNA telegram read: "The Canadian Nurses' Association takes this opportunity to affirm its support for members of the nursing profession employed by the government of Canada.

"CNA feels strongly that the salaries, conditions of work, and fringe benefits received by these nurses should be at least equal to those received by their provincial counterparts.'

The wire included the CNA position statement of April 1973 that remuneration for nurses "should be on the basis of a salary. This salary shall be adequate, competitive, and include recognition of responsibility, experience, educational qualifications, seniority, as well as income security benefits such as

sick leave and pensions.'

The Registered Nurses' Association of British Columbia, in a telegram to the prime minister and the minister of health and welfare, expressed its dismay at the arbitration award of October 18 for federally employed nurses. The wire said the RNABC "feels that such an award can only reflect that the federal government, by paying their employees second-class wages, is only prepared to provide second-class service to veterans and the native people of Canada."

The Alberta Association of Registered Nurses' telegram expressed "acute disappointment regarding the contents

of the arbitration award. The award reflects lack of understanding of the true worth of the nurse employee by placing the federally employed nurse at a salary level below that of her counterparts within the province."

Without the sanction of their collective bargaining group, nurses in various parts of Canada spontaneously staged short protests after the arbitration award was announced. In some centers, many nurses reported off sick on the same day; in others they held study sessions during working hours.

Ruth Sear, national chairman of the nurses' component of the Professional Institute of the Public Service, told The Canadian Nurse: "If nurses en masse were to leave their posts without warning, it would be irresponsible behavior. But when the nurses did protest, they made sure that patients were cared for and that no one suffered as a consequence. I felt great sympathy for the nurses."

Ms. Sear and other federally employ-(Continued on page 11)

#### 1974 Convention Fees

To make the 1974 CNA convention break even financially, CNA directors set the following registration fees: CNA member

\$40 Student \$15 CNA member, daily fee \$15 Student, daily fee \$45 Nonmember observer Nonmember observer, daily fee \$20

The convention will be held in Winnipeg, Manitoba, June 16 to 21. **CNA Supports RNAO Statement** On Nurse-Midwifery

Ottawa - Directors of the Canadian Nurses' Association supported the statement on nurse-midwifery, accepted by members of the Registered Nurses' Association of Ontario (RNAO) at their 1973 annual meeting in May (News, July 1973, p.12). Directors also accepted a motion that CNA develop a statement on nurse-midwifery, using the RNAO statement as a basis.

The RNAO statement says, in part ... "The nurse midwife blends the expertise of nursing with advanced knowledge and skills in maternity and infant care. She is prepared to manage the normal cycle and to provide expert care under medical direction, to high risk

The previous CNA statement on the subject of midwifery was a resolution in 1946, approving midwifery for outlying districts where doctors were not available.

Directors agreed that a new position statement is needed. One director said, "If we can't come up with a strong statement, don't come out with a bleached statement.'

Another director said, "In our province, we're saying that patients in the south of Canada shouldn't be deprived of the maternity health care that patients in the north receive.'

Research Committee Appointed, **Priorities Ranked By Directors** 

Ottawa - The CNA board of directors, meeting on October 18 and 19, 1973, appointed a 13-member special committee on nursing research for 1973-75. Directors also set priorities for the committee's tasks. Terms of reference for the special committee were set at the directors' meeting in April 1973. (See News, June 1973, p.5.)

Members named to the nursing research committee, from nominations by provincial nursing associations, are: Beverlee Ann Cox, Vancouver; Dr. M. Josephine Flaherty, London, Ont.; Joan M. Gilchrist, Montreal; Dr. Helen Glass, Winnipeg; Dr. Floris King, Halifax; Jacqueline Leger, Moncton; Margaret J. Rosso, Regina; Dr. Shirley M. Stinson, Edmonton; and Edna Walsh, Halifax. One additional member will be named from provincial nursing association nominees.

#### news

The other three members of the committee are: Pamela E. Poole, consultant in the research programs directorate, and Huguette Labelle, principal nursing officer, both of Health and Welfare Canada; and Dr. Helen K. Mussallem, executive director of CNA.

From the recommendations made by the 1971-73 research committee members, CNA directors gave top priority to the need for facts regarding; major characteristics/trends of community college nursing programs in Canada, nursing and nurses in community health centers (facts gathered in the field), use of staff in relation to new clinical roles in Canada, and how nurses are being evaluated in nursing service across the

Second priority was given to providing the directors with recommendations on the utility of a follow-up of employment patterns of new graduates, as of December 31, 1971; a critique of the current CNA five-year manpower-

prediction study; and recommendations regarding development of nursing research consultation services at the provincial and federal levels.

Cigarettes Butted, Ashtrays Gone And CNA Board Meeting Ends Early Ottawa - The Canadian Nurses' Association has taken a stand against smoking (News, June 1973, p. 15), and members should indicate they support this stand. This feeling was expressed by the CNA board of directors, who agreed to prohibit smoking during their meeting October 18-19, 1973. "We must put our money where our mouth

While the plan to stop smoking at all board meetings was being recorded, a CNA staff member quietly collected the ashtrays and hid them in the confines of CNA House.

is," said one member, as she spoke

against the habit.

The CNA directors' afternoon meeting on October 19 ended early.

#### **CNF Directors Elect Officers**, **Study Administration Costs**

Ottawa - Directors of the Canadian Nurses' Foundation (CNF) elected Gay Engensperger, Vernon, B.C., as president and Marilyn Riley, Halifax, vicepresident, at their meeting on 17 October, 1973, at CNA House.

Ms. Engensperger, a homemaker and active RNABC member, was co-author of the study of the foundation, done by one RNABC district. The study proposed the establishment of a permanent endowment fund for CNF. (News, July 1971, p.5.)

Ms. Riley is supervisor of clinical nursing at Victoria General Hospital, Halifax; she was a CNF scholar in 1968-70.

The directors also appointed a threemember ad hoc committee of the CNF board to study the problems of administering the foundation and to recommend solutions.

At the June 1973 meeting, the directors decided to pay an amount, not to exceed \$6,000, to defray the salary of the secretary working on CNF business. The Canadian Nurses' Association has covered all the administration costs of CNF for most of the foundation's 11-year history.

"A trend of declining membership [in CNF], the revenue from which is applied to the general fund to cover administration costs, poses a threat to the continued efforts of establishing CNF on an operationally independent basis," Dr. Helen K. Mussallem, secretary-treasurer of CNF, told the directors. Membership in CNF for 1973 is

(Continued on page 11)



#### get any intant urine specimen when you want it

regular and 24-hour collectors in newborn pediatric Sizes The sure way to collect pediatric urine specimens easily . . . every time . . . Hollister's popular U-Bag now has become a complete system. Now, for the first time, a U-Bag style is available for 24-hour as well as regular specimen collection, and both styles now come in two sizes . . . the familiar pediatric size and a new smaller size designed for the tiny contours of the newborn baby.

Each U-Bag offers these unique benefits: doublechamber and no-flowback valves ■ a perfect fit on boy or girl, newborn or pediatric protection of the specimen against fecal contamination # hypo-allergenic adhesive to hold the U-Bag firmly and comfortably in place without tapes ■ complete disposability.



Now the U-Bag system can help you to get any infant urine specimen when you want it. Write on hospital or professional letterhead for samples and information about the new U-Bag system.

HOLLISTER LIMITED . 332 CONSUMERS RD., WILLOWDALE, ONT.

# One squeeze says it all.

Pick up any Davol syringe

1 oz., 2 oz., 3 oz., 50 cc. or pistontype – and you'll notice the difference. It
feels right. And works right. Because it's
made right. With all the features of re-usables
to make your job easier. Yet priced for single
patient use. That's the Davol difference.
The better way. Try one. Try them all. Ask
your Davol dealer salesman for
details. Davol Canada Ltd.,
1033 Range View Road,
Port Credit, Ontario L5E-1H2.

Phone: (416) 274-5252.

New Duotone Design MRS. R. F. JOHNSON SUPERVISOR CHARLENE HAYNES ANN COHN, L.P.N.

# ne Pins 'n Things...from Ke

#### IT'S EASY TO ORDER REEVES NAME PINS FOR YOURSELF OR FRIENDS!

Choose style you want, shown left, Print name (and 2nd line if desired) on dotted lines below. Check other into in boxes on chart, clip this section and attach to coupon

bottom left. Attach extra sheet for additional pins. NOTE SAVINGS ON 2 IDENTICAL PINS... more convenient. spare in case of loss.

2nd LINE: PRICES. STYLE NO. Engraved 1 Line | Engraved 2 Lines ALL METAL . . . rich, trim and tailored. Lightweight, smooth edges, rounded corners. Does 1 Pin 2.25 7 1 Pin 3.00 ☐ Gold ☐ Silve apply LASTIC LAMINATE White Black broader; engraved thru surface to contrasting core color. Beveled border matches lettering. 559 2 Pins 1.65 2 Pins 2.60 apply White METAL FRAMED FRAMED . . Classic snow-white plastic with Gold Silve Black
Dk. Blu-1 Pin 2.25 MOLDED PLASTIC. ☐ 1 Pin .95 ☐ 2 Pins 1.65 1 Pin 1.58 2 Pins 2.60

\*Please add 25¢ per order for 3 pins or less.

QUANTITY DISCOUNTS: 10-24 pins, deduct 10% 25-99 pins, 15%; 100 or more pins, 20% -----------

#### NURSES PERSONALIZED ANEROID SPHYG.

ANEROID SPHTG.

A superb instrument especially designed for nurses! Imported from precision craftsmen in W. Germany. Essyto-attach Velero cutf, lightweight, compact, lits into soft sim. leather zippered case 25% x4 x x m. Dial calibrated to 320 mm., 10-year accuracy guaranteed to 23 mm. Serviced by Reeves if ever required. Your initials angraved on manometer and gold stamped on case FREE, for permanent identification and distinction. A wise investment for a lifetime of dependable service!

No. 106 Sphyg. . . 37.95 ea. No. 106 Sphyg. . . . 37.95 ea.



#### CAP ACCESSORIES

CAP TOTE keeps your caps crisp and clean while stored or carried. Flexible clear plastic, white trim, zipper, carrying strap, hang loop. Stores flat. Also for wiglets, curlers, etc. 8½" dia., 6" high.

No. 333 Tota . . 2.65 ea., 6 or more . . 2.35 ea. Your initials gold-stamped, add 50¢ per Tote



WHITE CAP CLIPS Holds caps TITLE CAT CLIPS Holds caps firmly in place! Hard-to-find white bobble pinks, anamel on fine spring steel. Eight 2" and eight 3" clips included in plastic snap box. No. 529 Clips. . . 3 boxes for 2.25, 6 for 65, ea., 12 for 60, ea.

CLAND

#### MOLDED CAP TACS

Replace cap band Instantly. Tiny plastic tac, dainty caduceus. Choose Black, Blue, White or Crystal with Gold Caduceus; or all Black (plain). The neater way to fasten bands. No. 200 Sat of 6 Tacs . . . 1.25 per sat. 12 or more sats 1.00 per set



METAL CAP TACS Pair of dainty jewelry quality Tacs with grippers, holds cap bands securely. Sculptured metal, gold finish, approx. 34" wide. Choose RN, LPN, LVN, RN Caduceus or Plain Caduceus. Gift boxed. No. CT-1 (Spacify Initials), No. CT-2 (Plain Cad.) or No. CT-3 (RN Cad.) . . . 2.95 pr.

SEL-FIX CAP BAND Black velvet Back velvet band material. Self-adhesive, presses on, pulls off; no sewing or pinning. Reusable several times. Each band 207 long, pre-cut to popular widths: ¼" (12 per plastic box) ½" (8 per box) ¾" (8 per box) ¾" (8 per box). Specify width under ITEM column on coupon.



CROSS PEN
World-famous ballpoint, with CROSS PEN World-famous ballpoint, with seculptured caduceus emblem. Full name FREE engraved on barrel (include name with coupon) Refills avail, everywhere. Lifetime guarantee.

No. 3502 Chroma 8.00 ea. No. 6602 12kt. G.F. 11.50 aa.

TO REEVES	COMPANY, Box	C . At	tlebor	o, Mass	62793	ì
DRDER NO.	ITEM	COLOR	512E	QUANT.	PRICE	
-						
-						L
			-		_	ľ

Use extra	sheet fo	r additional	items o	r orders.
-----------	----------	--------------	---------	-----------

INITIAL5 as desired: Good idea . . . for distinctive identification)

TO ORDER NAME PINS, fill but all information in box top right, clip but and attach to this coupon.

l enclose	\$	(Mass, residents add 3% S. T.)
	Sorry, no COD's or I	billing terms available
Send to	* • • • • • • • • • • • • • • •	

Street ..... State

MEDI-CARD SET Handiest reference ever! 6 smooth plastic cards (3½" x 5½") crammed with information, including Equivalencies of Apothecary to Metric to Household Meas, Temp-°C to °F, Prescrip, Abbr., Urinalysis, Body Chem., Liver Fests, Bone Marrow, Disease Incub, Periods, Adult Wgts.
All in white vinyl holder with gold stamped caduceus. No. 289 Card Set . . . 1.50 ea. 6 or more 1.25 ea. 12 or more 1.10 ea. Your initials gold-stampad on holder, add 50¢ per set. KELLY FORCEPS So handy for stainless steel, fully every nurse! 5½" stainless steel, fully guaranteed, Ideal for clamping off tubing. Your own initials help prevent loss.



Free Initials and Scope Sack with your own



Famous Littmann nurses' diaphragm stethoscope . . . a fine precision instrument, with high sensitivity for blood pressures, apical pulse rate. Only 2 ozs., fits in pocket, with gray vinyl anti-collapse tubing, non-chilling epoxy diaphragm. 28" overepoxy diaphragm. 28° over-all. Non-rotating angled ear tubec and chest piece beau-tifully styled in choice of 5 jewel-like colors: Goldtone, Silvertone, Blue, Green, Pink.\*

FREE INITIALS AND SACK! Your initials engraved FREE on chest piece; lend individual distinction and help prevent loss. Also FREE SCOPE SACK included, worth \$1. (Free sacks not personalized; add 50½ if initials desired.) Note big savings on quantify criders quantity orders.

No. 216 Nursescope . . . 13.80 ea. ppd. 6-11 . . . 12.80 ea. 12 or more . . . 11.80 ea. Group Discounts <u>include</u> free Initials and Sack!

"IMPORTANT: New "Medallion" styling includes tubing in colors to match metal parts. If desired, add \$1. ea. to prices above; add "M" to Order (No. 216<u>M</u>) on coupon.

No. 223 Scope Sack only . . . 1.00 ea. ppd. 6 or more 75¢ ea. Gold stamped initials, add 50¢

SCISSORS Precision-made imported forged steel.
Professional quality. Guaranteed 2 years.



31/2" LISTER MINI-SCISSORS Tiny, handy, stip into uniform pocket or purse. Choose jewelers Gold or gleaming Chrome plate linish on coupon No. 3500 Mini-Scissors . . 2 75 ea

41/2" or 51/2" LISTER SCISSORS As above, but larger for bigger jobs. Chrome finish only No. 4500  $(41/2^n)$  or No. 5500  $(51/2^n)$  Scissors . . . 2.75

51/2" OPERATING SCISSORS

Stainless steel, with sharp/blunt points. Beautifully polished finish. Ne. 705 DR Scissors . 2.75 ea.

All scissors above: 1 doz. or more (any style) . . . Your initials engraved, add 50c per scissors

CLAYTON DUAL STETHOSCOPE Light CLATION DARK weight imported dual scope; highest sensitivity for pulse rate. Chromed head tubes and chest piece 11/4" bell and 11/4" diaphragm, grey anti-collapse tubing, 4 oz., 29" long, Extre ear plugs and diaphragm included. Two initials engraved free. No. 413 Dual Steth . . . . . . 17.95 ea.

#### NURSES CHARMS

Finest sculptured Fisher charms, Sterling or Gold Filled (specify under COLOR on coupon). For bracelet or pendant chain. Add to your collection! No. 263 Caduceus; No. 164 Cap; No. 68 Grad. Hat; No. 8. Band. 5cissors . . 3.49 ea.

14K PIERCED EARRINGS

Dainty, detailed 14K Gold caduceur. Dainty, detailed 14K Gold caduceus, for on or off duty wear. Shown actual size. Gift boxed for friends, too. No. 13/297 Earrings . . . . . 5.95 per pair.

PIN GUARD Sculptured caduceus, chained to your professional letters, each with pinback/ safety catch. Or replace either with class pin for safety. Gold linish, gift boxed. Choose RN, LPN

No. 3420 Pin Guard . . . . 2.95 ea.

ENAMELED PINS Beautifully sculptured status insignia, 2-color keyed, hard-fired enamel on gold plate Dime-sized, pin-back. Specify RN, LPN, PN, LVN, NA, or

No. 205 Enam. Pin 1.95 ea., 12 or mora 1.50 ea.



Endura NURSE'S WATCH Fine Swiss-made waterproof timepiece. Raised easy-to-read white numerals and hands on black dial, luminous markings. Red sweep-second hand. Chrome finish, stainless back. Includes black velvet strap. Git-boxed, with 1 year guarantee. Very dependable. Includes 3 initials engraved FREE!

1093 Nurses Watch . . . . . . . . . 19.95 ea POCKET SAVERS Prevent stains and wear!
Smooth, pliable pure white vinyl. Ideal Smooth, pliable pure white viny low-cost group gifts or favors.

Mc. 210-E (right), two compartments with flap, gold stamped caduceus . . . 6 for 1.50, 25 or more 20 e ea.

No. 791 (left) Deluxe Saver, 3 compt. change pocket & key chain . . . 6 for 2.98, 25 or more 35¢ ea.



Nurses' POCKET PAL KIT

Handiest for busy nurses. Includes white Deluxe Pocket Saver, with 5" Bandage Shear (both shown opposite page), 1"ri-Color ball-point pen, plus handsome little pen light . . all silver finished. Change compartment, key chain.

No. 291 Pal Kit . . . . . . . 4.95 ea. 3 Initials engraved on shears, add 50¢ per kit.

BZZZ MEMO-TIMER Time hot packs, heat lamps, park meters. Remember to check vital signs give medication, etc. Lightweight, compact (1 ½" dia.), sets to buzz 5 to 60 min. Key ring. Swiss made.

No. M-22 Timer . . . . . 4.95 ea.

3 or more 3.95 ea.; 6 or more 3.50 ea.



EXAMINING PENLIGHT

White barrel with caduceus imprint, aluminum band and clip. 5" long, U.S. made, batteries included (replacement batteries available any store). Your own light, gift boxed. No. 007 Penlight . . . 3.98 ea. Your Initials engraved, add 50¢ per light.

CDM

#### news

(Continued from page 8)

775, a decrease of 176 members com-

pared to 1972, she said.

The ad hoc committee to study the problem is chaired by Fay McNaught, Winnipeg; other committee members are Appolline Robichaud, Fredericton, and Ms. Riley.

Directors appointed CNA board member, Glenna Rowsell, Fredericton, to the CNF board, replacing Roseanne Erickson, Calgary, who resigned.

CNF directors in 1973-74 will serve a one-year term, to make CNA and CNF boards' terms of office concurrent.

(News, August 1973, p.8.)

The Dr. Katherine E. McLaggan Fellowship of \$4,500, awarded in June 1973 to Sister Marie Bonin for doctoral study, has been returned for personal reasons, and one award for master's level study has been reduced to \$2,500 because the recipient has been partially funded through another source. The revised statement for awards for the 1973-74 academic year indicates that nine recipients share a total of \$26,500. (News, September 1973, p.12.)

#### (Continued from page 7)

ed nurses have met on separate occasions with Mr. Drury, Finance Minister John Turner, Mr. Lalonde, and others to try to "get something done about the disastrous award," Ms. Sear said.

The arbitration award to the federally employed nurses did not give the single national increase they had requested; the award gave Atlantic region nurses an 18.3 percent increase over two years and 13 percent in the same period to nurses west of the Maritimes. Only in Ontario and Saskatchewan do federally employed nurses receive pay equal to that of nurses working for other employers. "At the moment, there is parity in Saskatchewan but the first collective bargaining contracts are being negotiated in that province and then there will not be parity," Ms. Sear said.

Wally Firth, MP from Northwest Territories, speaking in the House of Commons on Nov. 6, supported the nurses' requests for increased salaries, danger pay, and increased sick leave and vacation leave for nurses working in the North. He also asked that Mr. Drury reopen negotiations with "this group of people who could have chosen the right to strike as a means of

#### CNA Statement on Specialization in Nursing

In keeping with its goal of the promotion of the highest possible standards of nursing care, the association recommends recognition of degrees or levels of specialization within the profession. CNA regards specialization as an inevitable concomitant of modern nursing that will permit nurses to acquire recently developed knowledge and skills and will facilitate use of manpower resources. At the same time, CNA believes that nonspecialist nurses will continue to play a preponderant role within the profession in virtue of their number, as well as through their influence.

It is the responsibility of the professional associations to evaluate the need for specialized nurses, to interpret their functions to allied professions and agencies—both governmental and private, to assist the specialization process to develop

in an orderly manner, and to develop norms of competence.

#### Education

Specialization is acquired through academic and clinical instruction following a basic nursing course — diploma or baccalaureate (although options might be offered at the baccalaureate level).

Specialized education should be offered by institutions of education. These institutions require the cooperation of the nursing profession, allied disciplines, hospitals, and health agencies in planning programs and clinical resources, as well as identifying future needs and priorities.

Levels of Specialization

Two types of program should be offered: postdiploma or postbasic and master's degree level.

Level 1 — courses of short duration, leading to the granting of the title "nurse specialized in . . ." (whatever the specialty may be).

Level 2 — courses traditionally offered at the master's degree level by universities, leading to the granting of the title "specialist in clinical nursing."

Areas of Specialization

Since CNA believes basic nursing education should prepare the nurse to perform competently in the fields of health maintenance and primary care, specialization in these fields should be acquired at the master's degree level. (It should be noted, however, that in the immediate future, additional courses may be necessary for practice in the primary care settings).

In the area of specialized care and services, priorities can only be established after identifying current nursing activities, reviewing health problems in

Canada, and assessing clients' needs for nurses' services.

Regulation

Regulation should be assumed by the nursing profession once research has determined the proper procedure. Until then, CNA will undertake the preparation of voluntary, temporary standards that would determine the requirements for the appellation of specialized nurse.

CNA supports the establishment of a group or society of specialized nurses and agrees with the principle of formal liaison between this group and CNA.

#### Remuneration

Existing CNA policy should apply to specialized nurses: remuneration should be on the basis of a salary that is adequate; competitive; and reflects responsibility, experience, educational qualifications, and seniority.

(Accepted by the CNA board of directors on October 18-19, 1973)

contract dispute settlement, but instead opted for arbitration."

In answer to a question by J.M. Forrestall, MP for Dartmouth-Halifax East, in the House of Commons on Nov. 6, Mr. Drury said that the arbitration award is final and binding. But the government would be prepared to undertake a study to be conducted

jointly by the departments employing nurses—the departments of national defence, veterans affairs, health and welfare, and the Canadian penitentiary service.

"This study will, in recognition of the evolution of the nursing profession, review the utilization and professional development of nurses, examine the Next Month in

#### The Canadian Nurse

- Protecting Nonsmokers in Public Places
- The Problem-Solving Technique:
   Is It Relevant for Nursing Practice?
- Clinical Laboratory Procedures



#### Photo credits for December 1973

Miller Photo Service, Toronto, cover photo

Rehabilitation Institute of Montreal, Quebec, pp. 20-24

Information Canada, Ottawa, pp. 33, 34

University of British Columbia, Instructional Media Centre, Vancouver, B.C., p. 37

#### news

work environment, relationships between employees and management, and other features and characteristics of the nursing group in the public service," he said,

In a letter, Mr. Drury told Ms. Sear, "The object of the study is to arrive at a conclusion that will ensure the high motivation of our nursing group on the maintenance of efficient nursing care."

In a telephone conference on Nov. 6, Mr. Drury's letter was read and discussed with nurses representing the regional subgroups of federal nurses in Halifax, Montreal, London, Toronto, Winnipeg, Regina, Calgary, Edmonton, Vancouver, Whitehorse, and Sioux Lookout. "Nurses will ask for representation on the study group," Ms. Sear told *The Canadian Nurse*.

Louise Tod, vice-chairman of the federal nurses, said: "Members of the executive of the federal nurses recognize that the arbitral award is final and binding. Nurses must abide by it.

"The only way the arbitration award could be changed would have been by a joint application by both parties (the treasury board and the federal nurses of Canada), to have the award amended. Mr. Drury chose not to consider this option, although evidence indicates that the award is grossly unfair to nurses employed in the federal services.

"In preparation for future negotiations, it can be anticipated that federal nurses will be considering the strike route in preference to arbitration," Ms. Tod told *The Canadian Nurse*. The next nurses' contract will be negotiated in the autumn 1974.

SRNA Ends All Involvement In Collective Bargaining After Supreme Court Ruling

Regina, Sask.—The nine-member council of the Saskatchewan Registered Nurses' Association has passed a resolution ending SRNA's collective bargaining responsibility.

This decision was taken as a result of the October 29, 1973 Supreme Court of Canada ruling on the Nipawin and District Staff Nurses' Association (News, August 1973, page 9).

The Supreme Court upheld the January 1973 decision of the Saskatchewan Labour Relations Board, which dismissed the Nipawin association's application for certification, on the grounds that it was assisted in its formation by a company-dominated

organization — SRNA — and thus not eligible for certification as a trade union under the Trade Union Act. SRNA includes nurses in managerial positions in its membership and frequently on its council.

With its new resolution, the SRNA council prohibits any council member, representative, or employee of the association from becoming involved in the formation or administration of a labor organization. It also prohibits interference, financial support, or any other support to such an organization.

At the same time, the council approved a motion that terminated the employment of SRNA's employment relations officer, who was responsible for the association's collective bargaining activities.

In the past, SRNA has assisted—financially and otherwise—those groups of nurses who wished to become certified as bargaining agents under the Saskatchewan Trade Union Act. It has also assisted a committee of general staff nurses, which has bargained with a committee of the Saskatchewan Hospital Association for a model agreement with respect to salaries and working conditions.

This voluntary form of provincial negotiations has been going on since 1968. The SRNA and SHA committees were to begin negotiations for a 1974 model agreement the last week of November, 1973. The current model agreement expires at the end of 1973.

At the annual meeting of SRNA last June, D.K. MacPherson, the association's legal consultant in labor matters, warned that if the Supreme Court upheld the labor relations board decision, the staff nurses' associations already certified would have to reorganize themselves, and a separate provincial association would have to be established for collective bargaining.

The Canadian Nurse has received comments from several persons in other provinces regarding the Supreme Court decision. C.R. Brookbank, a professor in the department of commerce at Dalhousie University in Halifax, Nova Scotia, said:

"This decision... has far-reaching implications for the future of nursing as a profession. It places in jeopardy the collective bargaining relationships that now prevail between nurses and their employers in almost every province.... If it becomes a precedent, the psychological division between senior nurses — many of whom are in administration — and their younger colleagues — many of whom are just starting out in the ranks — will widen."

As member-at-large for social and economic welfare on the board of directors of the Canadian Nurses' Asso-

(Continued on page 14)

DECEMBER 1973

# Pampers ones uboth abreak

#### Keeps him drier

Instead of holding moisture, Pampers hydrophobic top sheet allows it to pass through and get "trapped" in the absorbent wadding underneath. The inner sheet stays drier, and baby's bottom stays drier than it would in cloth diapers.



# Saves you time

Pampers construction helps prevent moisture from soaking through and soiling linens. As a result of this superior containment, shirts, sheets, blankets and bed pads don't have to be changed as often as they would with conventional cloth diapers. And when less time is spent changing linens, those who take care of babies have more time to spend on other tasks.

PROCTER & GAMBLE

#### POSEY FOR PATIENT COMFORT

The new Posey products shown here are but a few included in the complete Posey Line. Since the introduction of the original Posey Safety Belt in 1937, the Posey Company has specialized in hospital and nursing products which provide maximum patient protection and ease of care. To insure the original quality product, always specify the Posey brand name when ordering.

The Posey "Swiss Cheese" Heel Protector has new hook and eye fasteners for easy application and sure fit. Available in convoluted porous foam or synthetic fur lining. #6121 (fur lining), #6122 (foam), \$4.80 pr.

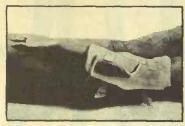


The Posey Foot Elevator protects pressure sensitive feet by keeping them completely off sheets. A washable flannel liner protects the ankle. Soft polyurethane foam ring with slick plastic shell allows patient to move his foot freely. #6530 (4 inch width), \$7.80.



The Posey Foot-Guard with new "T" bar stabilizer simultaneously keeps weight of bedding off foot, helps prevent foot drop and foot rotation. #6412, \$21.00.





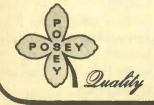
The Posey Elbow Protector helps eliminate pressure sores and friction burns. Three models are available. #6220 (synthetic fur w/out plastic lining), \$5.25 pair.



The Posey Ventilated Heel Protector helps prevent friction and skin breakdown while allowing free movement. The newly developed closure holds heel protector on the most restless patient. #6110 (w/plastic shell), \$7.80 pr.

Send for the free all new POSEY catalog - supersedes all previous editions.

Please insist on Posey Quality - specify the Posey Brand name.



Send your order today!

POSEY PRODUCTS
Stocked in Canada
ENNS & GILMORE LIMITED
1033 Rangeview Road
Port Credit, Ontario, Canada

#### news

(Continued from page 12)

ciation, Glenna Rowsell told *The* Canadian Nurse this was "an unfortunate decision." CNA has always said in principle that collective bargaining should come under the umbrella of the provincial associations, she pointed out.

"Nurses should be responsible for their own social-economic welfare," said Ms. Rowsell. She emphasized that all professional associations have some responsibilities in protecting the social-economic interests of their members, even though they may be limited in what they can do for certain groups by legislation. "That function is always with us," she added.

The Supreme Court decision does not affect nurses in New Brunswick, as their legislation is different, Ms. Rowsell noted. In that province, collective bargaining for nurses is carried out by the N.B. Provincial Collective Bargaining Councils, which employ Ms. Rowsell as employment relations officer. She is a consultant on social-economic welfare matters to the New Brunswick Association of Registered Nurses.

However, the situation in Ontario has been similar to that in Saskatchewan. The employment relations department of the Registered Nurses' Association of Ontario has helped hospital staff nurses' associations organize. These independent associations have to be certified as bargaining agents by the Ontario labor relations board, as in Saskatchewan.

Anne Gribben, director of RNAO employment relations, said it is "regrettable that the Supreme Court has upheld the Saskatchewan Labour Relations Board." The board did not make a wise decision, she said, because it did not prove there was management control.

According to Ms. Gribben, a nurse who sits on a professional association's board of directors is not there because of the position she holds. She is there as a professional representing nursing as a whole, and is not playing a partisan role.

"This type of ruling should not affect our collective bargaining," said Ms. Gribben, because "nurses have founded the Ontario Nurses' Association" (News, December 1973, page 15). The ONA is separate from the RNAO, but its status as a union has not been proven yet.

Labor legislation in both Ontario and Saskatchewan state that decisions

DECEMBER 1973

of the labor relations board cannot be appealed. Nurses in Saskatchewan have the right to strike, but nurses in Ontario do not have that right.

VD Program Involved Entire City Symposium On Gonorrhea Told

Ottawa — The first VD Counterattack program in Philadelphia resulted in a dramatic increase in the number of persons with gonorrhea who were treated in the city and also resulted in the introduction of VD education into 20 high schools, Joseph A. Chiappa told the International Symposium on Gonorrhea October 25.

In his report, the acting executive director of the United States Alliance for the Eradication of Venereal Disease described the organization and effectiveness of "VD Counterattack — the most comprehensive community VD involvement program of all time," which was carried out in Philadelphia.

This ambitious program was based on the idea that if masses of people can learn to think of VD objectively as a disease that anyone can get, that anyone can talk about, and that anyone can do something about, greater numbers of infected persons will seek diagnosis and treatment.

The organization of the VD Counterattack began in October 1971 and culminated in a march through the city in April 1972. Some three-quarters of the marchers were teen-agers. There were also 100 nurses and 200 medical students involved in conducting orientation sessions for the marchers and manning 28 temporary clinics.

In this Philadelphia Counterattack, the city was divided into 10 major districts that contained 50 orientation depots in the high schools. The goal was to recruit 50,000 volunteers who would each visit 10 homes to talk about VD. Although this goal was not completely realized, VD literature did enter some 400,000 homes.

Participation in the Counterattack included 25,000 citizens, 60 local businesses and civic organizations, and all the local television stations. More than \$200,000 worth of media time and space was donated.

Mr. Chiappa noted some of the results of the VD control program in Philadelphia: "More than 9,500 cases of gonorrhea were treated in the 12-month period over and above what could reasonably have been expected. Another almost unique phenomenon is that among privately-treated cases..., females outnumber males by 1.5 to 1. There are few other cities in which the situation isn't almost the opposite."

A second Philadelphia Counterattack is being planned and Counterattacks in as many as 150 U.S. cities are being

organized, said Mr. Chiappa. He also mentioned that the Pennsylvania Governor's Committee on VD has been organized to expand the program throughout the state.

Newfoundland Nurses Accept New Government Contract Offer

St. John's, Nfld. — Members of the nurses' bargaining unit who rejected a one-year collective agreement last August (News, October 1973, page 7), have accepted a new government offer.

The negotiating team of the Association of Registered Nurses of Newfoundland worked out a two-year agreement with the provincial government. This agreement gives a Nurse I a starting salary of \$6,900 retroactive to April 1, 1973 — a 15 percent increase over the 1971-73 rate of \$6,000. On April 1, 1974 a Nurse I will receive \$7,452 in step I — an 8 percent increase over the April 1973 rate.

In addition, full-time nurses on staff April 1, 1973, who continued on staff to August 31, 1973, received a block payment of \$200. On September 1, 1974, salary scales for all classifications will be increased by \$200.

In the past, nurses in the province did not receive recognition for their nursing experience. However, the new agreement does give recognition for previous experience. Nurses who were on staff March 31, 1973 will advance one step on the revised pay range, effective from April 1, 1973. Again on March 31, 1974, nurses who are on staff will advance one step.

During the year April 1, 1973 to March 31, 1974, one step for each two years of experience will be allowed on appointment. Between April 1, 1974 and March 31, 1975, nurses will be allowed one step for each two years of experience, to a maximum of three steps, on appointment.

This collective agreement covers some 2,000 RNs who work in hospitals and health agencies throughout Newtoundland.

Worldwide Gonorrhea Problem Brings Researchers Together

Ottawa — Because of the alarming increase in gonorrhea around the world since the 1960s, and the difficulty of diagnosis and control of this infectious disease, the health protection branch of Health and Welfare Canada invited researchers from various countries to an international symposium on gonorrhea October 24 and 25.

The technical aspects of diagnostic testing, the effectiveness of screening programs and of different antibiotics, and work being done on vaccines were among the topics on the program. One

U.S. researcher said that so far vaccines for gonorrhea have not been successful. Discussion showed that methods of treatment vary, but the drug of choice is still penicillin by injection.

Describing the seriousness of the gonorrhea problem in Canada, Dr. Stan Acres of the health protection branch noted that with one million visitors from overseas last year, "far more was exchanged than tourist dollars." Although gonorrhea rates are not as high as they were during World War II, more cases are being identified now than at any other time, he said.

Dr. Acres expressed pessimism about the control of the disease. He pointed out that only about 10 percent of gonorrhea cases are reported and that there were approximately one-half million cases in Canada last year. Of the three methods of control — contact tracing, education, and case detection — the latter is "one of the few rays of hope on the horizon now," said Dr. Acres.

Most of the invited speakers were from the United States. Dr. Arnold Schroeter of the Mayo Clinic School of Medicine in Rochester, Minnesota, explained: "Gonorrhea in the male is predominately a symptomatic disease, motivating most patients to seek medical attention; nevertheless, approximately 5 to 11 percent of males seen in the venereal disease clinics are asymptomatic. However, 80 percent of females with gonorrhea are asymptomatic and remain in the population as an

infectious reservoir . . . . "
Dr. H. Hunter Handsfield, U.S.
Naval Hospital, Long Beach, California, referred to a study of 100 women with acute salpingitis — "the most costly form of gonorrhea" because of its prevalence, cost of hospitalization, and high rate of resulting infertility.

Compared with patients seen in a Seattle, Washington, VD clinic, 23 percent of the women in the study had an intrauterine device in place when salpingitis developed, compared with 10 percent among patients in the VD clinic, Dr. Handsfield reported. He said, "This suggests that the presence of an IUD is a factor which predisposes to acute salpingitis."

Dr. Robert Rendtorff, a professor in the department of community medicine at the University of Tennessee, spoke of the cost of uncontrolled gonorrhea in women. "It is the female coming to the hospital with the onset of an acute episode of . . . pelvic inflammatory disease (PID) or with other complications of gonorrhea that looms as today's number one VD problem."

Dr. Rendtorff said PID is the greatest complication of gonorrhea in women. The sequelae of PID constitute a group of conditions that can "add

appreciably not only to the cost of the disease, but to the devastating effects on the patient. These include recurrences and relapses of the infection or abscess formation, as well as chronic pelvic pain and menstrual abnormalities. Sterility... is an old and well-recognized problem ...."

He told his audience: "It is important to recognize that the majority of the serious sequelae of PID often appears months to years after the gono-

coccus has done its damage."

No mention was made during the symposium of basic education for nurses, although two nurses participated in reaction panels. Gail Wright, a nurse epidemiologist with the Ontario Ministry of Health in Toronto, said the nurse usually has the first contact with the person who wants information on VD and is afraid he has a problem. Nurses must correct misunderstanding and misconceptions, she added.

Ms. Wright said it is vital for the nurse to understand both her role on the health team and the epidemiological implications of infection. She also described the one-day seminars and three and a half-day courses for nurses she conducts in health units throughout

Ontario.

A young nurse from British Columbia offered interesting observations about the problems associated with the influx of transient young people in Vancouver and the response to their needs for housing and health care.

Trudi Ruiterman, who is with the British Columbia department of health services in Vancouver, referred to the work nurses are doing in some of the new free clinics in the city. One of these is a women's clinic, where women are motivated to treat themselves and learn to do smears and cultures. A male nurse from the B.C. health department works at a clinic for homosexuals one night a week.

"The free clinics in Vancouver see 800 to 900 kids a month," Ms. Ruiterman told *The Canadian Nurse*. She also pointed out that British Columbia is the only province where VD clinics are run by nurses. "We rely a lot on public health nurses to carry out the

VD program," she added.

Alberta Nurses And Hospitals Accept Conciliation Board Award

Edmonton, Alta. — Staff nurses' associations and hospital boards in the 51 hospitals involved in group bar-

gaining to amend the contract that expired on March 31, 1973, have accepted a conciliation board award giving the nurses a salary increase of 21 percent over two years on a base salary of \$550 a month.

The new salary for a staff nurse, effective April 1, 1973, starts at \$605. Effective November 1, 1973, it is \$625 and April 1, 1974, \$665.

The proposal presented by the Alberta Association of Registered Nurses on behalf of the 51 staff nurses' associations was similar to the proposal accepted by the nurses at Edmonton's Royal Alexandra Hospital earlier this year (News, July 1973, page 12).

Yvonne Chapman, AARN employment relations officer, explained that the Royal Alexandra Hospital and its staff nurses' association were not involved in the group bargaining, which began in January 1973, because the contract at the hospital expired three months before the other contracts.

According to Ms. Chapman, AARN and the Alberta Hospital Association developed the system of group negotiations to avoid duplication of effort and to shorten the bargaining process. To participate in the group, a collective agreement must be in effect, both the staff nurses' association and the individual hospital board must wish to participate, and authority to bargain must be given to AARN by the staff nurses' association and to AHA by the hospital board involved.

If either the staff nurses' association or the board of a hospital choose to remain outside the group, negotiations take place on an individual basis at the

local level.

The AHA has recommended that the terms of the group award be incorporated into the personnel policies of those hospitals without a formal collective agreement.

Ont. Red Cross Society Offers Bursary To Nurses

Toronto, Ont.—A \$1,000 bursary is being offered by the Volunteer Nursing Committee of the Ontario division, the Canadian Red Cross Society, to graduate nurses registered in Ontario.

The award for the 1974-75 academic year will enable an Ontario nurse to undertake further studies in nursing at the degree level. The successful candidate will be selected on the basis of training, nursing experience, and leadership qualities. Consideration will be given to the applicant's expected contribution to nursing in Ontario.

Interested nurses may obtain application forms and further information from: Eleanor Mitchell at The Canadian Red Cross Society, 460 Jarvis Street,

Toronto, Ontario, M4Y 2H5. Applications must be submitted before March 15, 1974.

Code For Nurses Among Topics
Discussed By ICN Committee

Geneva, Switzerland — The new professional services committee of the International Council of Nurses met at ICN headquarters September 3 to 5, 1973. Discussion of the Code for Nurses, the ICN definition of "nurse," and career ladder concepts in nursing

highlighted the meeting.

At its September meeting, the committee finished the wording of the Code for Nurses. Last May, the CNR adopted the Code with two amendments, one noting that aspects of the "spiritual environment" should be included. The wording adopted for addition to the Code is: "The nurse, in providing care, promotes an environment in which the values, customs, and spiritual beliefs of the individual are respected."

The Code for Nurses is now available in English, French, and Spanish versions from ICN headquarters. The cost

is \$.75 (U.S.).

After receiving information on the definition of nursing adopted by the CNR in Mexico, the professional services committee decided that terms used in the definition will need clarification.

The definition adopted in May by the CNR states: "A nurse is a person who has completed a program of basic nursing education and is qualified in her/his country to provide responsible and competent professional service for the promotion of health, the prevention of illness, the care of the sick, and rehabilitation. Basic nursing education is a planned educational program, which provides a broad and sound foundation for the effective practice of professional nursing and a basis for postbasic education."

The committee agreed to recommend to the ICN board of directors "that the definition be examined not only for use as a membership criterion, but also as a general statement to be used by national associations in identifying nursing practice." This recommendation will go before the ICN board in March

1974.

Committee members began preliminary discussions of the concepts of the career ladder in nursing. They agreed that at their next meeting they would concentrate on the movement of nurses from one category to another, on movement within the nursing hierarchy, and on careers within the health fields. The committee is studying this issue to make recommendations to the ICN board of directors on action ICN should take.

# Here is a new, fast and sterile way to prepare Xylocaine infusions

for life threatening arrhythmias



# **Xylocaine®**

(Lidocaine Hydrochloride Injection, Astra Std.)

ne Gra

- The special 5 ml transfer syringe contains 200 mg/ml Xylocaine and can be added to infusion set-ups without removing solution from infusion flask or bag
- Cuts preparation time in half
- · Easy and convenient to use
- Adds another link to the sterility chain
- Disposable
- Clearly labeled for positive safeguard against error

ASTRA Pharmaceutical Division, Mississauga, Ontario



New 8th Edition!

#### Mosby's COMPREHENSIVE REVIEW OF NURSING

A close examination of the entire spectrum of nursing, this respected work correlates nursing arts and basic science knowledge with clinical nursing. Revised to incorporate current ideas and developments, it features expanded coverage of medical-surgical, pediatric, and rehabilitation nursing. A completely updated section on fundamentals discusses the changing health care system the problem solving process, and more. By an editorial panel of 12. September, 1973. 8th edition, 645 pages plus FM 1-XII, 7¼" x 10½". Price, \$11.05.

New Volume IV!

#### CURRENT CONCEPTS IN CLINICAL NURSING

Lively articles deal with vital topics in four major nursing fields. The psychiatric section discusses the nurse as a therapeutic agent working with persons in other health disciplines. Implications for individuals in all phases of the life cycle are explored in the maternity nursing section. The medical-surgical section features articles on patients with specific injuries and pinpoints legal aspects of nursing. The need to work with children in their total family situation is emphasized in the pediatric section. Edited by EDITH H. ANDERSON, R.N., Ph.D.; BETTY S. BERGERSEN, R.N., Ed.D.; MARGERY DUFFEY, R.N., Ph.D.; MARY LOHR, R.N., Ed.D.; and MARION H. ROSE, R.N., Ph.D.; with 43 contributors. December, 1973. Volume IV, approx. 448 pages, 7" x 10", 37 illustrations. About \$17.60.

New 2nd Edition! Burrell-Burrelll

#### INTENSIVE NURSING CARE

Thoroughly updated, this edition includes two new chapters: one on basic anatomy and physiology of the nervous system; the other on burns, prepared with the expert assistance of another Mosby author, Florence Jacoby. Further discussions outline: salient points of physical examination; mechanisms of shock; new electrode placing; and central venous pressure monitoring. A reorganization of drug classification makes primary and secondary drug effects more easily understood.

By LENETTE OWENS BURRELL, R.N., B.S., M.S.N.; and ZEB L. BURRELL, Jr., A.B., M.D., F.A.C.P. June, 1973. 2nd edition, 360 pages plus FM 1-XV1, 7" x 10", 84 illustrations with drawings by WEONA WRIGHT. Price, \$10.25.

A New Book! Fowkes-Hunn

#### CLINICAL ASSESSMENT FOR THE NURSE PRACTITIONER

Recognizing the fact that you face increased responsibility for patient care, the authors provide an overview of the clinical diagnostic process. Discussions include: the essentials of patient history-taking; performing a physical examination; keeping meaningful patient records; and ordering and interpreting appropriate laboratory studies. By WILLIAM C. FOWKES, Jr., M.D.; and

VIR GINIA K. HUNN, R.N., B.S.N. August, 1973. 190 pages plus FM 1-X, 7" x 10", 36 illustrations, Price, \$6.30.

New 3rd Edition! Cherescavich

#### A TEXTBOOK FOR NURSING ASSISTANTS

As nursing matures into a truly clinical and therapeutic profession, the role of the nursing assistant similarly matures. This volume focuses on the nursing assistant as a team member in the health care delivery system, providing practical advice on patient needs and how the assistant can best meet these needs. Emphasis is placed on the use of disposable equipment, with material on reusable types deleted. By GERTRUDE D. CHERESCAVICH, R.N., B.S.,

M.S. June, 1973. 3rd edition, 442 pages plus FM I-XII, 7" x 10", 179 illustrations. Price, \$10.00.



start off '74 with these new books from

TIMES MIRROR

THE C. V. MOSBY COMPANY, LTD. 86 NORTHLINE ROAD TORONTO, ONTARIO M48 3E5

# Independence for phocomelic children

The thalidomide babies in Canada are preteens now, and those who have upper-extremity phocomelia need additional skill training. Children who earlier accepted help from parents and teachers now want and need to be independent. The author describes ways in which these limb-deficient children may be assisted to become more independent.

Denise Mauger Côté, P/OT Reg.

Some mothers who took the drug thalidomide during the period of gestation when limb buds were being formed had children with phocomelia, which is an absence of the central elements of the limb. This means, literally, "limbs like a seal." All of the deformities seen in the thalidomide babies are found in one form or another in sporadic cases elsewhere and occur from other causes as well.\*

In Eastern Canada the phocomelia produced by thalidomide is more prominent in the upper than the lower extremities. The thalidomide babies are preteens now, and those with phocomelia need additional skill training. Children who carlier accepted help from parents and teachers now want and need to be independent, especially in dressing and toileting themselves.

#### Linda

Linda is a 10-year-old girl who was born with short, bilateral, upper-extremity phocomclia. On the left side, she has one finger attached to her shoulder; the limb measures, from the top of the acromion to the distal end of the finger, approximately 7½ cm. On the right side, the limb is approximately 9 cm long and has two little digits attached to a partial hand.

When first evaluated at the age of 12 months, she was not using her upper limbs at all, except for sucking the right one. At the age of 15 months, she was fitted with bilateral upper-extremity prostheses, which she has used quite regularly since then. Linda wore her prostheses only for specific activities so she was also encouraged to use her phocomelic hands, to increase their function. Prehension of small and light objects is possible by adduction of the two fingers of her right hand, but limited because of the size of the fingers. When holding heavier or larger objects, Linda stabilizes them between the palmar

Ms. Côté was assistant head of the occupational therapy service at the Rehabilitation Institute of Montreal at the time this article was written. She is a graduate of the physio-occupational therapy program at the School of Rehabilitation, University of Montreal, Montreal, Quebec.

<sup>\*</sup> California, University at Los Angeles, Child amputee prosthetics project, *The Limb-deficient Child*, Berkeley and Los Angeles, University of Calif. Press, 1963.



Figure 1: Linda uses the long-handled, double fork covered with plastic to push her pants down.

aspect of her hand and her chin. Movements at shoulder level are possible, but limited and weak.

Her hand is positioned in adduction to the chest, slightly bent and mostly supinated. Movements exist in the left finger but they are limited. This digit can only be used to hold something light by flapping it against her chest.

Because of the length of her hands, Linda cannot reach for objects and must compensate by using her mouth or her tongue and by using many trunk and leg movements. She cannot join her two hands, and all bilateral activities are impossible with her phocomelie hands.

Linda goes to a regular school where she is now in sixth grade. At school, she performs most of her activities with her prostheses, but at home, when not wearing artificial arms, she uses only her right hand, whose function is limited.

Until recently, Linda was dependent for most activities of daily living. She could eat independently with her phocomelic hand, but it was difficult. She could undress almost independently, using her feet and her mouth to pull clothes down and to remove them; whenever possible, she used her right hand.

To undress, Linda must first remove her prostheses, which she wears over a short-sleeved sweater or under a shirt. To cover the prostheses, she wears a long-sleeved smock, blouse, or dress, opened at the front and fastened with Velcro, as she cannot do buttons. When both the prostheses and the smock are removed, she can proceed to undress.

The only difficulty Linda encountered was to pull slacks and panties down; Linda said she used a door knob at home to push her pants down over her hips and then she pulled them off with her feet. To dress, she used mainly her feet and needed a lot of assistance.

To make her as independent as possible, a long-handled hook was given to Linda (Figures 1,2). At the beginning, she could scarcely handle the hook because of the limited strength and movement in her right hand, but after a few weeks of practice she succeeded.

Linda was dependent on help to go to the bathroom; to avoid problems at school, she was trained to go at a specific time during the day while at home, where she could have help. When she is wearing her prostheses, Linda cannot, for the time being, go to the bathroom alone, as the prostheses inhibit free movements of the trunk which are essential to pull pants down and up. If she removes her prostheses, which she can easily do without help, she is then able to manage by using the hook to pull her pants down and up.

Because of the length of her hands, she cannot use toilet paper to wipe herself after urinating. She was given a plastic spatula, slightly curved, around which she wraps the toilet paper (Figure 4). By holding it with her right hand and bending forward with her legs apart, she can reach far enough to clean herself.

Linda has reached a degree of independence while being trained, but it will take time and practice for her to become independent,

#### Limitations

A child, born with deformities of one or more limbs, will experience some

**DECEMBER 1973** 

limitations during the different phases of motor-development and probably later, when mastering manual skills and functional daily activities. These limitations may be minimal if the child develops compensations or substitution patterns that permit him to follow the normal process of development.

To achieve a certain independence, a limb-deficient child must compensate for the limitations of his upper limbs by using his mouth, legs, feet or movements of his trunk to reach and to pull up and to push down his clothes.

The child with severe bilateral deformities of the upper extremities who has some means of prehension, such as partial hands and digits, should be less limited than the one who has stumps, as he will be able to grasp, hold, pull, and stabilize, using adduction or flexion of his fingers.

For the past 18 months, a program has been carried out at the Rehabilitation Institute of Montreal with a group of 10- to 12-year-old youngsters with phocomelia, including Linda, to help them achieve independence in activities of daily living (ADL), especially self-care: toileting and dressing.

Although all children in this group have bilateral upper-extremity phocomelia, both sides are not equally involved. The length of the phocomelic hand varies from one digit attached to the shoulder, to part of an arm and/or a hand with fingers, which reaches approximately half-way between shoulder and waist level.

The position of the phocomelic hand also varies from one child to another, but in most cases the hand is lying against the chest in adduction, flat or slightly curved in flexion. All fingers are not functional, that is, they cannot be used for prehension and manipulation because of limitations in range of motion, stiffness of joints, and deviation, and also because of muscular weakness. The movements (elevation and abduction) in the proximal part of the limb are, in most cases, limited and weak.

With a longer phocomclic hand, an articulation is present between the hand and the shortened arm; movements of flexion and extension are possible, but

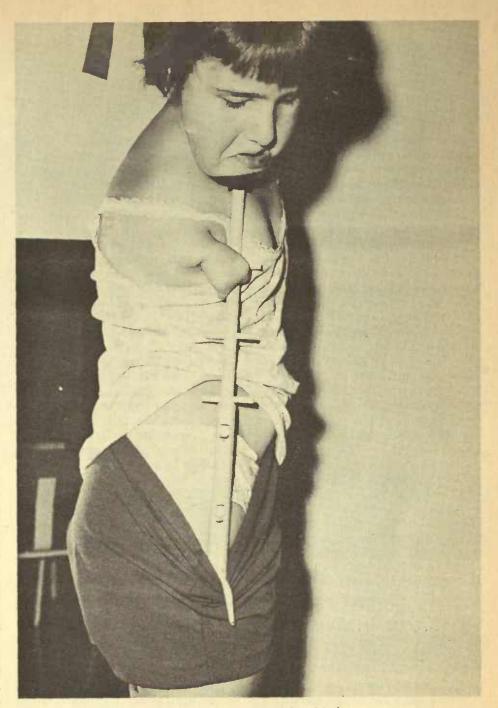


Figure 2: A suction cup at the top of the hook lets Linda use her chin for pushing down.

the child cannot always extend his hand and maintain it in this position without using his mouth, his chin, or his cheek to assist the movement.

#### Dependence

The future problem of dependence in ADL, such as dressing, undressing, and toileting, was evident at initial evaluation when the children were babies. The decision at that time was not to anticipate those problems but to wait until they arose. This happened when the phocomelic children entered regular school; they were expected by

their teachers to be able to look after themselves as their classmates did.

A first attempt to search for independence was made at that time with a few phocomelics, but without much success. We realized that to carry out the ADL training, the child has to be highly motivated to manage on his own and that the cooperation of his parents, especially his mother who spends more time with him, was important.

The mother's attitude toward the independence of her child influences his performance greatly. This is why, prior to referral to the occupational

THE CANADIAN NURSE 21

therapy department for the functional evaluation, the mother or both parents are seen by the physiatrist and the social worker. The parents are informed about their child's condition and about what they can expect from him, and they are helped to accept him positively, seeing him with what he has, and not with what he is missing. The importance of parental collaboration is stressed, because whatever the child will learn while being trained for independence must be practiced regularly at home, so he can perform all activities easily and achieve a good functional speed.

The purpose of the evaluation of a limb-deficient child, as it is done in occupational therapy, is to observe how the child uses the remaining parts of his upper limbs in different activities and to detect substitution patterns, if any are present.

With our group of phocomelic patients, the major problems of dependence were noted in self-care activities, such as dressing and undressing, hygiene, and toileting. All children whom we evaluated and trained in our recent program are attending regular school, except for one who is in a special class because of hearing and speech problems associated with the limb-deficiencies. The children were independent for feeding and for most school activities, such as writing, cutting with scissors, manipulating papers and books, and for play activities.

Their physical limitations in different activities were due to the inability to reach waist and hip level because of the length of the upper limbs, lack of strength and movement to pull up and push down with phocomelic hands, muscular weakness in finger movements, and difficulty in using both phocomelic hands simultaneously.

#### **Training**

Knowing the functional limitations of each child, we organized a training program that aims at maximum independence.

First, functional and play activities are done with the child to improve function in both phocomelic hands. We try to increase the range of movements at shoulder level and to strengthen

the prehension, or the grip, of the fingers. The child is supervised closely so he will not use substitute movements.

The second step toward independence is to develop maximum mobility of the spine, specifically of the lumbar region, and mobility of the hips so the child will be able to reach the perineal region with his phocomelic hands, for personal care. The movements of abduction, external rotation, and flexion of the hips are encouraged to enable the child to use his feet for different activities.

The use of feet is not specifically stimulated for functional activities, but the child with severe upper-limb deficiencies is not discouraged to use them; for some activities, such as personal care, it is the only way for him to become independent. If the child lives in a normal milieu and goes to a regular school, he will not be accepted socially if he uses his feet for activities such as eating and writing; but in his private life, he should be free to act according to what is best for him. The important factor is his independence, no matter how he achieves it.

#### Clothes

The type of clothes the child wears is an important factor when searching for independence. If he wears loose-fitting pants and underwear, front-opened shirts and dresses, he will be able to dress and undress independently without the use of adaptations.

Specially designed or adapted clothes are avoided as much as possible and only recommended to the parents if the child cannot manage otherwise. These clothes make the child look too different from other children and demand time and initiative from his mother, who will have to make or adapt her child's clothes. If special clothes have to be used, the therapist will adapt one sample and try it on the child to demonstrate to the mother and to practice with the child while he is being trained; then the mother will adapt other clothes at home.

We have discovered that standard clothes, opening in the front, fastened with zippers instead of buttons, and loosely fitted will facilitate independence. We also suggest that parents choose pants with loose elastic at the waist instead of a waist band fastened with snaps, hooks, or buttons, which the child may not be able to manage without adaptations.

Silk or cotton underwear or pantics, instead of those made of stretchy material, are strongly recommended as they will slide up and down the hips easier and without rolling. Some simple adaptations that are hardly noticeable can be made easily: buttons, hooks, or snaps can be replaced by Velcro (self-adhesive material tape); a metal ring can be attached to a zipper to provide a better grip for the child to pull it up and down.

Adaptations

After trying to reduce to a minimum his physical limitations, the third step of training is to encourage the child to use all substitution movements that he can when accomplishing activities or part of activities with which he needs help.

If, after all, he cannot succeed, adaptations may enable him to reach complete independence. But we emphasize to the child, and also to the parents, that these adaptations will not work miracles — the minute the child uses them, he will not be automatically independent. They will be useless without daily practice, without the child's motivation to use them, and without the parents' acceptance and cooperation.

It is important to avoid the use of too many adaptations for self-care activities, adaptations that the child will have to carry with him wherever he goes: home, school, or visiting friends and relatives.

One adaptation has been given to every child trained for independence. It is a long-handled, double hook covered with Plastisol (liquid plastic covering) that enables the child to reach waist and hip level to pull up and to push down panties, pants, and leotards. (Figure 1). The long-handled hook has two or three transverse sticks, inserted at different levels, which provide a better grip on the handle.

The suction cup at the top of the long handle enables the child to push down on the hook using his chin, as

22 THE CANADIAN NURSE

many children do not have enough strength to push with their phocomelic hands (Figure 2).

A suction hook on the wall can also be used to bring pants down and up; it is used by children who cannot use their upper limbs to hold and stabilize the long-handled hook. Hip, body, and leg movements are used to move the pants up and down with the suction hook (Figure 3).

For toileting, the dependency of the child is mostly caused by his inability to push pants down and pull them back up, and to use toilet paper. By using the long-handled, double hook, the child will be able to remove his pants and underpants to go to the bathroom; an adaptation can be used to hold toilet paper with phocomelic hands and wipe himself after urinating. A plastic spatula, slightly bent at one end, is used; toilet paper can be wrapped around it (Figure 4). By holding the spatula with one phocomelic hand and bending forward as far as possible with both legs abducted, the child can reach the perineal region and wipe himself (Figure 5).

To discard the paper, the child slides the spatula against the toilet bowl and the paper falls down. Some children who cannot use both hands simultaneously encounter difficulties in wrapping the paper. A slit can be made longitudinally in the bent part of the spatula to stabilize the paper when starting to wrap it around; it does not make discarding the paper more difficult.

The use of toilet paper to clean themselves after bowel movements is still a problem for most children. Attempts to render the phocomelic child independent for this activity have been made by trying different adaptations. Up to now, perhaps because of lack of motivation or because of the inadequacy of those adaptations, only a few children are using them and they still need close supervision from the mother.

Even with the use of these adaptations, the child is not considered funetionally independent unless he achieves, by regular practice, a certain speed that will enable him to go to the bathroom without taking too much time.

Phocomelic children can manage to wash their hands and face and even **DECEMBER 1973** 

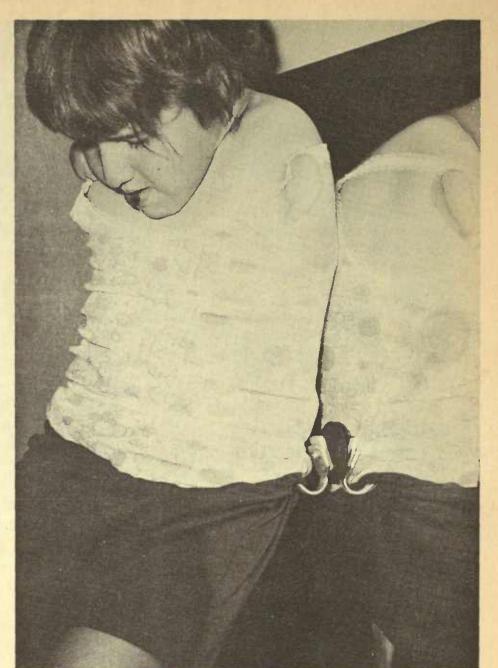


Figure 3: Hip, body, and leg movements are used to pull the pants up with a suction hook fixed on the wall. Linda uses a hook fastened to a mirror.

brush their teeth, unless the length of the upper limbs and the prehension are too limited; if so, the child can achieve independence by using his feet to perform these activities. When taking a bath, these children wash their face, hands, and upper part of the chest with the phocomelic hands, and the lower part of the body by using their feet. To reach their back, either with the upper limbs or with the feet, the child must use a long-handled brush or sponge.

#### Demonstration

The last step, but not the least, of the independence training program is to demonstrate to the parents the performance of the child and the use of the different adaptations given to him. Most of the time, the mother will come to observe or it may be an older sister who usually helps the child at home.

A home program is discussed and planned so it will not be too demanding on the family time and energy and, of course, on the child. It is important for the child to do things for himself, but this rule must not be carried so far that the child is deprived of a helping hand when he gets into difficulties.

The child is not expected to dress independently every morning until he can do so within a reasonable time. If the child spends half an hour to an hour



Figure 4: To wipe herself after urinating, the phocomelic child uses a slightly bent, plastic spatula wrapped with toilet paper.



Figure 5: By holding the spatula with her phocomelic hand and abducting her legs, Linda can reach the perineal region to wipe herself.

dressing in the morning, he will be forced to get up too early to be on time for school. On the other hand, it must be realized that up to recently he relied on his mother, or other members of his family, for hygiene and dressing, and now he has to accomplish these activities on his own. If he is pushed too much, he may feel neglected. It is essential that the child does a bit every day, and maybe more on the weekend where the schedule is not so rigid, so he keeps his mobility, the strength and dexterity in his hands, and also increases his speed and his working tolerance.

Following the training program, both child and parents must be aware that to reach total independence will take time, regular practice, a lot of motivation from the child, and his parents' cooperation. It is reassuring for both the child and his family to realize that if one day he is alone, he will be able to manage most of the activities of daily living, slowly but independently.

The functional problems that have

been dealt with up to now are those of a 10-year-old child. As he grows older, other problems will arise, but if the child has already achieved a degree of independence, it will probably be easier to solve new problems as they come.

Independence for self-care activities has been stimulated without the use of prostheses, because most of the children evaluated and trained had no artificial arms, having good function in their upper limbs. However, two children with phocomelia are wearing, to school, bilateral shoulder disarticulation type of prostheses, attached to a Vitrathene (soft-plastic sheeting) jacket. Because of this jacket, the body motions are limited and so are the movements of the hands.

Independence for toileting is almost impossible when wearing the artificial arms, as the prostheses, due to mechanical limitations, cannot be of any help for this type of activity. Independence is encouraged at home, when the child does not use his prostheses; other techniques of training are presently being developed to achieve independence when wearing upper-extremity prostheses.

#### Summary

Only a small group of limb-deficient children has been evaluated and trained, but it is evident that the problem of independence varies from one child to another and also depends a lot on the family situation. Each child achieves a different degree of independence and uses the same adaptation in a different way and for different purposes, depending on his needs.

# The pandemic influenza of 1918

Spanish influenza charged swiftly across the world at the close of World War I, causing more death and disruption than any plague before or since. The author knows few who remember the horror of its suddenness and found only scattered records on which to build her account.

#### Gladys Morton

On November 11, 1918, the First World War came to an end. While millions danced in the streets, millions more were dying of Spanish influenza. It was to be the most destructive pandemic ever known on this planet. The London Times of that day reported: "Never since the Black Death has such a plague swept over the face of the world. Never perhaps has such a plague been so stoically accepted."

Sir McFarlane Burnet, an Australian virologist who is possibly the most eminent authority alive, estimates that between 25 and 50 million died of Spanish influenza, most in the brief period between the beginning of October and the end of December 1918. Beside it the Black Death pales, with 25 million dead over a period of two years, 1348-50.2

The Encyclopedia Britannica reports: "In the autumn of 1918 much of the northern hemisphere was blanketed in influenza in approximately one month." In fact, few places on the globe escaped; St. Helena and New Guinea were among them.

#### **Symptoms**

The incubation period and onset of the disease were so short that apparently healthy people were suddenly overcome, and within an hour could become helpless with fever, delirium, and chills. Severe headache, pains of varying intensity in muscles and joints,

acute coryza, inflammation of the upper respiratory tract, accompanied by temperatures of 101° to 105°, were common but not unusual for influenza.<sup>5</sup> But what was unique, was the often fatal viral pneumonia that quickly followed even slight exertion. It could occur at any time during the illness—a patient could be convalescing one day and dead the next.

During an interview with Dr. Charles Mitchell, honorary professor, Department of Microbiology and Immunology, University of Ottawa, I asked about this phenomenon: "Was there an explanation for the pneumonia? Did the virus behave differently than in other pandemics?"

"Yes," he said, "in the majority of specimens of Spanish influenza that I examined, the virus had attacked the parenchyma of the lung. Normally, Type A influenza virus infects the mucous surface of the lung, but in 1918 it entered the organ itself. This was undoubtedly the cause of the swift, often fatal, pneumonia that frequently followed exertion."

He continued, "I was a young pathologist stationed at Lethbridge, Alberta, when flu broke out, and was soon up to my elbows in influenza specimens.

The author, now a free-lance writer, earned her R.N. during World War II at the Royal Victoria Hospital school of nursing, Montreal. Quebec.

One day the porter brought me a kidney and a piece of lung. I asked him if the patient had died recently."

"Yes," he said, "just this morning."
"Do you know his name?" He did.

"My God," I said, "that's my insurance agent. I called him two days ago and I have an appointment with him tomorrow." The man had been sick less than a day.

Wiser than most to the tragedy of exertion, Dr. Mitchell and his wife took precautions against coming down with flu by stocking the shelves with fluids, placing their beds in front of the fire, and arranging that the caretaker look in on them should the inevitable day arrive, which it did. And throughout their illness, neither budged from the bed until their temperatures were again normal.

Not so wise was my own uncle, Russell Main of Pincher Creek, Alberta. While convalescing from flu in hospital, he hopped out of bed to assist a nurse with a delirious patient and died 48 hours later of pneumonia. His two brothers arrived home from overseas to face, not the warm welcome they expected but the shock of a sudden tragedy.

#### Age of incidence

Although influenza has occurred in epidemics since recorded time, easily diagnosed by its symptoms, it has traditionally been considered a minor,

THE CANADIAN NURSE 25

even humorous, ailment. In the seventeenth century it was known as "the jolly rant," "the new delight," and "the gentle correction." But, for the very young and the very old who have always provided the mortality statistics, it was a wry form of humor. In the 1918 pandemic, a curious reversal occurred, and the "joke" was on the healthy young adults, those between the ages of 20 and 40, who provided 60 percent of the deaths. This phenomenon was unique to Spanish influenza and has never been explained.

Where it began

No one knows where the disease started. In his book *I Remember Him*, Hans Zissner suggests that it began over the course of several years from a large number of points of origin.<sup>8</sup> Or, it may have started in an overcrowded army camp in Kansas, March 11, 1918. On that day, 107 patients were admitted to hospital suffering from a sudden acute form of flu that quickly enveloped the 26,000 personnel, many of whom were destined for the war in France.<sup>9</sup>

But, for those over 60 who remember the event, the harbingers of Spanish influenza were the cold, exhausted troops in the filthy trenches of France.

Whatever its origin, the pandemic did not begin in Spain. However, since the King of Spain was one of the early victims, his country, by implication, was saddled with the responsibility and the name.<sup>10</sup>

#### Canada

With a population of barely eight million, Canada lost 30,000,<sup>11</sup> including 108 doctors from Ontario and the prairie provinces alone. Deaths in Ontario had reached 5,000 by November.<sup>12</sup>

The musty pages of *The Ottawa Journal* of October 1918 report: "Street cars rattle down Bank Street with windows wide open and plenty of room inside. Stores open at 10 A.M. and close at 4 P.M. Civil servants are let off at 3 P.M. for last-minute shopping. Schools, vaudeville theatres, movie palaces are dark; pool halls and bowling alleys, deserted."

One eager group confronted the mayor with a request that liquor prohibition be eased for those who needed a little "nip" to calm the nerves. But the only strong thing in Ottawa was the formaldehyde used to disinfect the street cars. A black-edged notice from the Bell Telephone Company urged its customers to make emergency calls

only, since most of their staff were sick. A front page plea for nurses and women to make pneumonia jackets and masks fought for attention with the exuberant news of the last days of the war.

#### **United States**

Influenza was first reported in America August 28, at a naval hospital in Chelsea, Massachusetts.<sup>13</sup> It spread rapidly over the entire United States, attacking possibly 20 million<sup>14</sup> and killing 548,000.<sup>15</sup> Life insurance claims from October 1 to December 24 were \$52 million.<sup>16</sup>

Although virulence was constant across the nation, it varied widely in local areas, with adjacent communities reporting enormous differences in death rates. Curiously, a change in the weather at the time of onset affected mortality in eastern American cities. When the temperature and humidity rose, the death rate rose, and when they fell the death rate also fell; no change in weather caused no change in mortality.17 Philadelphia had the highest mortality in the east, with 650 dying in a single day, and an overall rate of 210 per 100,000, as compared to Milwaukee, with 21 per 100,000.18

Schools, churches, and theaters were closed. There was public concern about isolation techniques in hotels where sick and dead were removed from rooms that were then cleaned with general mops and dusters.

Teachers became nurses, and doctors were run off their feet and into their graves. In parts of Wisconsin, every doctor was sick. Police and social workers found entire families helpless, children neglected, and the dead unattended. In some cases, whole families were found dead. For want of care, healthy children were taken to hospital with their sick and dying parents. A New York City doctor made 50 calls in one city block in a day and had to refuse more.

The only protection advised, or indeed known, by the medical authorities—isolation and face masks (improvised by stretching three layers of butter muslin over a tea strainer)—was, according to one doctor, as much use as a diver's suit and handcuffs.<sup>19</sup>

My search for material in the medical journals of the day was hampered by the absence of volumes for 1918 and 1919. However, the *American Journal of Public Health* is extant and helped fill the gap with such reports as this:

"The epidemic is known to have caused so many fatalities within a few days, that it is safe to say that morbidity preceded mortality by a few days at most." 20

And then this surprising observation: "The cause of the lower incidence of flu among colored people during the epidemic may have been due to the prevalence of tuberculosis among negroes. There seems to be some unexplained resistance to flu among tubercular patients."<sup>21</sup>

As for those unfortunate enough to be pregnant during those few months, the *American Journal of Medical Sciences* reports: In a study of 1350 cases of pregnant patients with influenza, almost half developed pneumonia, and of these 50 percent died.<sup>22</sup>

The American Journal of Public Health also reported that mortality aboard troop ships was twice that on land. Possible reasons for this were: the food was poor; the men ate little and then washed their mess kits in a communal tub of tepid water, using their hands to wipe off the food; they slept badly on unfamiliar hammocks in brightly lit holds; and, for their two compulsory showers during the crossing, the men were lined up naked on deck to await a sloshing of icy sea water. Needless to say, when this report was made public, future troops fared considerably better. 23

For those who were sick at disembarkation, mortality was in direct ratio to the distance from the nearest hospital.<sup>24</sup>

#### Europe

The disease spread just as quickly in Europe, with a death rate to match. Every member of the tiny Swiss army had to take to his bed. American doctors in France treated 70,000 of their own troops, with 32 percent mortality. England suffered 150,000 dead in November and December. Half the population of Manchester became sick, with 7.9 percent mortality. <sup>25</sup>

I was fortunate to find an eyewitness with firsthand experience. Margaret St. Louis, an articulate senior citizen of Ottawa, was, in 1918, an 18-year-old volunteer army nurse stationed at Reading, England. Even today, she remembers with sadness the events of those months, although her future husband was one of her patients.

"It happened so suddenly. In the morning we received an order to open

DECEMBER 1973

up a new unit for flu and by night we'd moved into a converted convent. Almost before the desks were out the stretchers were in -- 60 to 80 to a classroom. We could hardly squeeze between the cots. And oh, they were so

"They came from a nearby air force base, boys from all over the Empire. Some had been lying unattended for days. They all had pneumonia. We knew those whose feet were black wouldn't live.

"Two classrooms were made into morgues and they were always full. At the time of the Armistice on November 11, the epidemic was at its height, and between 15 and 20 died in each ward every day. It was awful!

"But we did what we could, and they were wonderful patients. We fed them beef tea and brandy every two hours. They all had to be fed. And we applied linseed poultices and gave them liquid aspirin every four hours. There was only time for a bed bath every second day, but we sponged the sickest [patients] as often as we could.

"Pneumonia jackets were so scarce that we grabbed them from the convalescent and the dead, washed them by hand, and hung them to dry by the open fires. My hands were raw from washing these jackets.

"But the sickest boys I have ever seen were those who had just been burned with mustard gas and then took flu. Their eye sockets were burned; the insides of their ears were burned, and, of course, their lungs. We put those poor lads outside for extra oxygen."

#### Elsewhere

Bad though it was in the western hemisphere, Spanish influenza was many times worse in Asia, although records are hard to find. The mortality rate for India was six times that of the United States, with 12,500,000 dead, or 4 percent of the population.26 More Indians died than during all the active combat of the First World War. Journalists reported that bodies littered the streets, and cemeteries were piled high with corpses. The flu swept like a tidal wave through China, but few had either time or training to record it.

The death rate for South Africa was 27 per 100,000 and, in the ghettos of Cape Town, 2,000 children were suddenly orphaned and destitute.27 Tangiers was reduced to the level of starvation, and the roads to the cemeteries were blocked with funeral processions.28

But the highest incidence of all was on the island of Samoa, where 80 percent of the population was sick at the same time, with 25 percent mortality. A medical unit from Australia could do little more than feed the living and bury the dead.29

#### Conclusion

Like the hurricane it seemed, Spanish influenza had spun itself out by the beginning of March 1919. For those who survived it, it took a full year to feel entirely well again. But recover they eventually did. Dr. Mitchell says that for months after he was up and around he wore his socks over his pant legs to keep out the draft. Extreme exhaustion, feelings of weakness, and fragility made the work day long and

The virus itself, Type A influenza, was not discovered until 1933. Before that time influenza was thought to be caused by Pfeiffer's bacillus. But even today, with our advanced knowledge of viruses, we have no effective prevention or cure for influenza.

Because the virus was most vicious in the stratum of population that carried the greatest responsibility — the wage earners and the parents of young children — it caused more disruption to family life than the war itself.

For those who remember, Spanish influenza was a tragedy of unforgettable proportions, vivid forever in their minds. But for the rest of us, it is a vague name from the past, with no poems, no novels, no plays - just a few scattered statistics to mark its place in history.

#### References

- 1. Burnet, Sir McFarlane. Natural History of infectious diseases. New York, Cambridge University Press, 1962, p.308.
- 2. Black death. Encyclopedia Americana. 4:33, 1959.
- 3. Influenza. Encyclopedia Britannica. 12:347, 1960.
- 4. Burnet, op. cit., p.298.
- 5. Darling, Chester A. Epidemiology and bacteriology of influenza. Amer. J. Pub. Health, 8:10:752. Oct. 1918.
- 6. Burnet, op. cit., p.294.
- 7. Tuesday morning joint session of laboratory and public health sections. Influenza discussions. Amer. J. Pub. Health, 9:2:134, Feb. 1919.
- 8. Zissner, Hans. I remember him. Boston, Little Brown, 1940(?), p.250.

- 9. Turner, Barry. Europe 1919: The influenza pandemic. In History of the 20th Century, London, Purnell for BPC Publ. Ltd., n.d. vol. 2, p.896.
- 10. Ibid., p.896.
- 11. Influenza. Encyclopedia Canadiana, 5:277, 1967.
- 12. The influenza epidemic of 1918. Canadian Annual Review 1918, p.574.
- 13. McConnell, Guthrie. The relation of the bacillus influenza to the recent epidemic. Amer. J. Med. Sci., 158:48, Jul. 1919.
- 14. Turner, op. cit., p.896.
- 15. Influenza. Encyclopedia Britannica, 12:347, 1960.
- 16. The influenza epidemic of 1918, op. cit., p.574.
- 17. National Research Council, Washington, D.C. Bulletin No. 34 (vol. 6. part 3) July 23, 1923. Prepared for the Division of Biology and Agriculture and the Division of Medical Sciences, National Research Council, and presented by Elsworth Huntingdon, Chairman. Report of the Committee on atmosphere and man.
- 18. Davis, William H. Influenza epidemic as shown in the weekly health index. Amer. J. Pub. Health, 9:1:51. Jan.
- 19. Maloney, Thomas E. Thursday morning special influenza conference. Amer. J. Pub. Health, 9:2:137, Feb.
- 20. Davis. op. cit., p.50.
- 21. Frankel, Lee K. and Dublin, Louis 1. Influenza mortality among wage earners and their families. Amer. J. Pub. Health, 9:10:734, Oct. 1919.
- 22. Harris. Influenza complicating pregnancy. JAMA, 72:978, 1919.
- 23. Lynch, Charles and Cummings, James G. The distribution of influenza by direct contact - hands and eating utensils. Amer. J. Pub. Health, 9:1: 25, Jan. 1919.
- 24. Meader, F.M. et al. Account of an epidemic of influenza among American troops in England. Amer. J. Med. Sci., 158:396, 1919.
- 25. Turner, op. cit., p.896.
- 26. Influenza. Encyclopedia Britannica 12:347, 1960.
- 27. The influenza epidemic of 1918, op. cit., p.574.
- 28. Turner, op. cit., p.896.
- 29. The influenza epidemic of 1918. op. cit., p.574.

## Myasthenia gravis

Expert nursing care and thorough teaching enable the patient to weather a crisis and cope with this neuromuscular disease.

Joan Stackhouse

With gentle, quiet efficiency the nurse moved to suction her patient's tracheostomy, deflate his cuff, and reposition him. Her movements were deliberate and relaxed. He motioned weakly in a prearranged signal and she held a writing slate in place. "Weaker — sudden," he scrawled.

"You're suddenly feeling weaker?" She spoke in calm, measured tones. "All right. We'll be watching you closely and give you what you need." She checked his grip and timed the downward drift of his arms, then moved quickly to the telephone. Moments later the doctor arrived to inject the edrophonium (Tensilon) she had prepared. Immediately the patient opened his eyes and smiled broadly. The dramatic improvement of myasthenia gravis symptoms following the Tensilon test was elearly evident, indicating the patient's need for increased cholinergic medication.

The myasthenia gravis patient requires the highest degree of professional nursing skill. His condition can fluctuate rapidly and with apparent inconsistency. He is usually alert and therefore subject to the emotional trauma of his total dependency and the stress of the ICU environment. The anger, frustration, and fear this patient feels are almost overwhelming. His future life-

style and his family's are very much influenced by the quality of teaching and counseling he receives in the hospital.

Myasthenia gravis is a chronic disease characterized by severe weakness and fatigability of various voluntary muscles. It is not a rare disease. Although myasthenia gravis is now diagnosed more frequently, it is estimated that half of all myasthenics are undiagnosed and untreated. Suspecting the disease is still the most important factor in diagnosis. There are an estimated 30,000 cases in the United States. The number of cases in Canada is unknown.] The female to male ratio is six to four. The onset is usually insidious and tends to begin in women between the ages of 15 and 40, and in men over 50, although the disease is also seen in children. Although its etiology is unknown, a defect exists at the neuromuscular junction that causes inadequate transmission of impulses by acetylocholine across the synaptic eleft.1

Evidence suggests that myasthenia gravis is an autoimmune disorder. Serum antibodies acting against voluntary muscles and certain thymic cells have been identified in myasthenic patients. The high incidence of thymic hyperplasia, the increased number of

germinal centers within the thymus, and the fact that thymectomy often produces a remission of symptoms also support the theory that the disease is an autoimmune process. Remissions and exacerbations are characteristic of myasthenia gravis, and it is frequently associated with other diseases thought to be autoimmune, for example, rheumathoid arthritis, lupus erythematosis, and certain thyroid diseases. Infection often causes a worsening of myasthenic symptoms, and treatment with immunosuppressives, corticotropin (ACTH), and prednisone is sometimes effective.<sup>2</sup>

Approximately one-fifth of all myasthenics have ocular myasthenia (see table, page 31), and their symptoms do not progress to more serious forms of the disease. Spontaneous remissions are common in this group. On the other hand, these patients often respond poorly to treatment and some must resort to an eye patch to control diplopia.

Persons with generalized myasthenia have some weakness of voluntary muscles and experience various levels of fatigue. Some patients have difficulty walking, climbing stairs, or rising from a chair, but little or no diplopia or severe bulbar symptoms. Others move their limbs with near-normal strength but have such severe bulbar symptoms

DECEMBER 1973

they can barely talk or swallow. Aspiration and airway occlusion are threats. Respiratory arrest secondary to severe weakness of the diaphragm and intercostal muscles is also possible. The danger of drug toxicity is another hazard, especially in brittle myasthenics. They tend to tolerate only low doses of medication and, therefore, to go rapidly into either myasthenic or cholinergic crisis.<sup>3</sup>

Drug therapy

Cholinergic drugs are the backbone of treatment of myasthenia gravis. With proper medical management, most patients can lead virtually normal lives. The disease was usually fatal until, in 1934, Dr. Mary Walker noted the similarity of myasthenia to curare poisoning and administered physostigmine, the curare antidote, to her myasthenic patient.4 Improvement was dramatic. Since then, analogues of physostigmine, neostigmine bromide (Prostigmin), and pyridostigmine bromide (Mestinon) have been the drugs of choice in the treatment of myasthenia. Ambenonium chloride (Mytelase) is sometimes used. Drug dosages are carefully manipulated to produce maximum strength with minimal side effects. Most patients prefer Mestinon because it has a longer, smoother action than Prostigmin and causes fewer side effects. Mytelase is the most toxic of the drugs, but produces maximum strength in some patients.

Cholinergic (anticholinesterase) drugs enhance the effect of acetylcholine at the neuromuscular junction. Normally acetylcholine carries the nerve impulse across the junction to the muscle end plate, and is then destroyed by cholinesterase enzyme. The way is then cleared for transmission of the next nerve impulse. In myasthenia gravis, the impulse is transmitted poorly and becomes progressively weaker. Various theories have been proposed as to the exact location and meehanism of the defect, but the answer is still unknown. However, we do know that inhibiting the action of cholinesterase permits acetylcholine to accumulate in sufficient amounts to transmit impulses more adequately, and that this increases muscle strength. Cholinergic medications do not enable a patient to use his muscles as he did before his illness, but he does become stronger. Enough medication to permit

a full return of strength may constitute an overdose, causing extreme weakness and threatening life. The symptoms of over- and underdosage are similar (see list below) and differentiation is sometimes difficult even for experienced persons.

Tensilon is a valuable tool in diagnosis, dosage adjustment, and differentiation of over- and underdosage. It is effective for less than five minutes. A one cc. syringe is filled, using a 10 mg.lcc. vial of Tensilon. Initially, 2 mg. are injected intravenously. After several seconds, the patient is evaluated and another 2 mg. are injected. This is repeated until 10 mg. have been given. The patient is evaluated at 30-second, 60-second, and 3-minute intervals.

The patient's baseline strength should be established before Tensilon is given. If he improves, the test is positive and his symptoms are myasthenic. An increase in medication may be indicated. If the patient becomes worse after Tensilon administration, his symptoms are cholinergic and medication is reduced or temporarily withdrawn. A double-blind placebo technique, using saline, is frequently employed to insure validity. Intravenous atropine should be available for use as an antidote when a Tensilon test is performed, in case a severe cholinergic reaction occurs.

Atropine sulfate is used to reduce cholinergic side effects, such as gastrointestinal hyperirritability, which leads to severe cramps and diarrhea.

#### CHOLINERGIC SYMPTOMS

Symptoms similar to myasthenia:
difficulty in swallowing
difficulty in chewing
difficulty in speaking
generalized weakness
difficulty in breathing
apprehension

Symptoms peculiar to excessive cholinergic therapy:
abdominal cramps and diarrhea nausea and vomiting increased, copious secretions: salivation sweating lacrimation bronchial secretions fasciculations blurred vision



Ms. Stackhouse prepared this article after caring for a group of myasthenia gravis patients. "However," she writes, "initial 'interest' was thrust upon me in 1954 when I was diagnosed as having myasthenia gravis while I was living in Cameroun, West Africa, and working for the Presbyterian Church." Two years later she underwent a thymectomy which resulted in a complete remission after six years. During the eight years the disease was active, she had "considerable experience with the problems that confront a myasthenic." In 1961, she organized the Kansas City Chapter of the Myasthenia Gravis Foundation

After her remission, Ms. Stackhouse worked as assistant teacher-therapist at a day treatment center for schizoprenic children, but nursing continued to hold a strong attraction, and she earned an A.A.S. degree from Rockland Community College, Suffern, New York. She worked full time as a medical-surgical nurse and in a coronary care unit before studying for her B.S.N. degree at Columbia University, New York, N.Y. Now a public health nurse with the Rockland County Health Department, Pomona, N.Y., she also teaches parttime at Rockland Community College. Her third child, born when Ms. Stackhouse's myasthenic symptoms were severe, lives at home. One older child is in college; the other is with the Peace Corps.

Copyright Sept. 1973. The American Journal of Nursing Company. Reprinted from *American Journal of Nursing*.

Atropine dries the secretions stimulated by cholinergic drugs. Some patients must take atropine daily, but they should be encouraged to take as little as possible since atropine tends to mask the warning signs of impending cholinergic crisis

Ephedrine is occasionally used to potentiate the actions of cholinergic drugs, and ACTH is sometimes given to patients who have not responded well to cholinergic medication. Usually, 100 units of ACTH are administered daily for 10 days. Since ATCH can cause an initial worsening of myasthenia, it should be administered only in an ICU, where the patient with a tracheostomy has access to a positive pressure respirator. Remissions induced with ACTH usually last from three to six months, so repeated courses are required. Recently, oral, high single-dose prednisone has produced good results in several reported cases. This is still a controversial treatment, but some people predict that prednisone will prove to be the drug of choice in treating myasthenia gravis,5

#### **Thymectomy**

In 1939, Dr. Alfred Blalock induced a myasthenic remission by performing a thymectomy, and since then surgery has been an increasingly accepted form of therapy. The best results occur in young women, without thymoma, who have been myasthenic for fewer than five years. However, thymectomy is recommended with greater frequency for men and women up to age 40 who have had the disease more than five years and who are not well controlled on anticholinesterase medication. The thymus is frequently irradiated preoperatively. Results are promising, but remission may not occur until long after thymeetomy. A recent study of 267 patients indicated that a remission or improvement was seen in 76 percent of them.6

The patient should be prepared preoperatively for the possibility that remission may be partial, may not occur for months or years following thymectomy, or may never occur. Since he has depended on cholinergic drugs for months or years, his fears of being off medication during the surgical period must be relieved with careful explanations of how his needs will be anticipated and safeguarded. A system must be devised, with prearranged signals, so that he can communicate his needs, and explanations given that his breathing and swallowing will be eased by a tracheostomy, respirator, and nasogastric tube. If the sternal split incision is to be used, the patient should be prepared for a sternal wound. Low doses of meperidine (Demerol) are usually ordered for pain.

Postoperatively, the patient should be positioned with the aid of a lifting sheet to minimize strain on the incision. A hemovac or chest tubes may be used. Sterile suctioning technique is important to prevent bronchial and wound infection. Antibiotics are often given prophylactically, and all measures employed to prevent atelectasis and pneumonia. Careful monitoring for myasthenic or cholinergic symptoms is crucial, especially when cholinergic medication is being reintroduced.

Newly diagnosed myasthenics and regulated myasthenics with few symptoms are frequently hospitalized for medication adjustment. Staff should be prepared for the possibility of a crisis. Equipment to manage a respiratory arrest, a spirometer, and intravenous preparations of Tensilon, atropine, and Prostigmin should be readily available.

Either myasthenic or cholinergic crisis can be recognized by the patient's ventilatory distress, difficulty in handling secretions, and severe weakness. He is usually transferred to an ICU. In cholinergic crisis, medications are withdrawn for at least two to three days. Although he is very ill, the patient remains alert and terribly afraid. He needs the support of a calm, competent nurse who constantly reassures him that he will weather this storm, that he will not be left alone. It is very important that he have his own nurse or nurses who care for him consistently.

A baseline of muscular strength must be established and changes closely monitored. Various methods can be used to test the strength of muscle groups, like counting the times the patient can blink his eyelids, raise his arms, or cross his legs, and measuring the degree of ptosis with a ruler. Strength of grips can be measured using a dynometer, or a count made of the times and distances he can pump up the blood pressure machine. Vital capacity should be measured regularly, using the same spirometer each time. What can be swallowed and how many swallows are tolerated should be observed and recorded. Testing is done in relation to the times medication is given. That is, maximum strength can be expected one hour after Mestinon is given, and deteriorating strength three to four hours later. If the opposite

occurs, a Tensilon test may determine if the patient's weakness is due to overmedication.

Because infection causes an exacerbation of the disease, the nurse must do everything possible to prevent infection by employing sterile techniques and promoting pulmonary hygiene. A nasogastric tube is usually kept in place to supply fluids and calories. Milk tends to stimulate secretions and should be avoided when necessary. Careful scheduling of care to allow maximum rest should be combined with steps to prevent the hazards of immobility. Special skin care is needed to cope with the diaphoresis and diarrhea that occur with a cholinergic crisis. Constipation should be treated with mild eatharties and suppositories, not enemas, since enemas tend to precipitate a sudden. collapse. Weakened eyelids frequently prevent complete closure, and methylcellulose should be used as a conjunctival lubricant to prevent corneal damage.

Of all the stresses confronting these putients in crisis, the inability to speak is the one they mention most often. When they are strong enough to write, a "magic slate" or pen and paper may be used. If his voice is fairly strong and secretions minimal, the patient's tracheostomy may be corked periodically while the cuff is deflated so he can speak. Otherwise the nurse must learn to read lips or arrange a series of signals to be used when the patient is too weak to move. A small hand bell to ring when he cannot call for assistance helps him feel less vulnerable since he can hear it and know that help is being summoned.

#### Patient teaching

The patient's need for reassurance cannot be overemphasized. Conversation about the hopeful aspects of myasthenia, and facts about the disease he will want to know when at home are helpful. Above all, the nurse should allow him to express his anger, fears, and frustations. When the crisis lasts for weeks, as it often does, the patient's despondency deepens. This dependence on the nurse grows and can place a great strain on her.

Patient teaching is done best after he has left the ICU and is again breathing on his own, eating, and speaking. Although he may have expressed a wish to die when he was in crisis, he now dares to believe he will survive and feels it is worth the effort to learn about his illness so that he can manage at home. Things he was told earlier now

should be repeated and reinforced. His family must be included in the teaching — and one should not assume that to be told means to be taught. They must know exactly whom to call, where to go, and what to do in an emergency. If the patient is prone to crisis, he should be provided with an Ambu bag and suctioning equipment when he is discharged. He should carry a medical identification card or bracelet.

Patients should learn the difference between myasthenic and cholinergic symptoms, and when and how to take atropine. Unless he is very experienced and stable, a myasthenic should never alter his medication without consulting his doctor. He should be encouraged to lead a normal life, with no activities restricted if he feels able to do them. However, he must maintain a regular schedule, take and record medications exactly as ordered, and eat his meals 30 minutes after taking his medication for optimal chewing and swallowing. Medication taken with a small piece of bread, cracker, or milk may help reduce gastric irritability and nausea. He can avoid excessive fatigue by alternating activities with rest periods, getting a good night's sleep, and pacing himself carefully toward the end of the day. Techniques of self-testing and timing his strength can be introduced. He should be taught to avoid exposure to infection, emotional stress, and activities like frequent stair climbing, that require considerable effort and repetitive movements.

Women should know that menstruation may temporarily worsen their condition, that pregnancy usually is not contraindicated, and that a normal delivery is possible. Some babies born to myasthenic mothers develop a transient neonatal myasthenia in the first few days of life, but it responds readily and permanently to treatment within a few weeks. Young mothers may feel guilty when they are unable to manage all the physical care of their young children. They can be helped to re-order their priorities and to understand that physical care is only one aspect of good mothering.

Many drugs should be avoided or used cautiously by myasthenic patients. These include morphine, ether, quinine, succinylcholine, curare, Innovar, strong cathartics, quinidine, procainamide, steroids (unless given as treatment for myasthenia gravis), and antibiotics that act on the neuromuscular junction, such as streptomycin and neomycin. Sedatives and narcotics should be given in

#### CLINICAL CLASSIFICATIONS OF MYASTHENIA GRAVIS

Ocular myasthenia

Involves ocular muscles only (ptosis and diplopia)

Very mild

Usually responds poorly to medication

No mortality; high rate of spontaneous remission

Generalized myasthenia

Mild

Slow onset, usually ocular; gradually spreads to bulbar and skeletal muscles but spares respiratory system

Responds well to medication

Remission possible

Low mortality rate

Moderate

Gradual onset, usually ocular; progresses to more severe bulbar symptoms and generalized involvement of skeletal muscles

Responds to medication less satisfactorily

Restricts activity

Remission possible

Low mortality rate

Acute fulminating myasthenia

Rapid onset of generalized skeletal weakness and severe bulbar symptoms; involves respiratory system early

Rapid deterioration

Incidence of crises (myasthenic and cholinergic) frequent

High mortality rate

Late severe myasthenia

Severe symptoms develop at least two years after onset of ocular or generalized myasthenia

Marked bulbar involvement

Progresses gradually or with sudden deterioration

Responds poorly to medication

High mortality rate

Adapted from Osserman, K.E.: Myasthenia Gravis. New York, Grune and Stratton, 1968, p. 80.

reduced doses when necessary.3 Patients should be cautioned never to take any medication unless prescribed by a doctor who knows them.

Help from every source, hospital and community, should be enlisted - from psychiatry, the chaplaincy, social services, rehabilitation, and others. Many patients benefit from the psychological support and publications of the Myasthenia Gravis Foundation, 230 Park Avenue, N.Y., N.Y., Help Is On Way, A Handbook for Patients, newsletters, and drug bank information. [There is no similar organization in Canada. However, anyone wishing information should write to: Muscular Dystrophy Association of Canada, 387 Bloor St. East, Suite 203, Toronto 5, Ont.]

Most myasthenic patients live full, rich lives despite their disability. Many of them eredit much of their success to a particular nurse who nurtured them skillfully and taught them well when they needed help so badly.

#### References

- 1. Merritt, H.H. Textbook of Neurology, 4ed. Philadelphia, Lea and Febiger, 1967. p. 549.
- 2. Kinney, A.B., and Blount, M. Systems approach to myasthenia gravis. Nurs. Clin. North Amer. 6:441. Sept. 1971.
- 3. Myasthenia Gravis Foundation, National Medical Advisory Board. Myasthenia Gravis: a Manual for the Physician. New York, The Foundation, 1970, pp. 16-17.
- 4. Greene, Raymond. Myasthenia Gravis. Philadelphia, J.B. Lippincott Co., 1969.
- 5. U.S. National Institute of Neurological Diseases and Stroke. Myasthenia Gravis Research Program, Washington, D.C., U.S. Government Printing Office, 1971. p. 4.
- 6. Perlo, V.P. et al. The role of thymectomy in the treatment of myasthenia gravis. Ann. N.Y. Acad. Sci. 183:308-315, Sept. 15, 1971.

## It's a skater's show on the Rideau

Carol Dworkin

Ottawa winters have not been the same since 1970. That was the year the National Capital Commission (NCC) froze four miles of the water-drained Rideau Canal into an unrivaled skating rink. Each winter since, a smooth, white artery has connected the National Arts Centre, in the scenic heart of the city, with Hartwell's Locks at Carleton University.

The only variable in the season is the weather, which can be counted on to provide at least three months of good skating a year. When the temperature is 10 to 15 degrees above zero — considered ideal for skating — brightly clad figures can be found zigzagging at any hour along this icy corridor. The canal rink is open 24 hours a day.

As many as 600,000 persons take advantage of the Rideau rink each season. Many arrive in buses from other cities, such as Montreal, Toronto, and Syracuse, New York. On a record weekend in February 1973, 52,000 skaters turned out.

#### Recreation for all

The NCC, which is responsible for the 50 miles of parkways in the national capital region, has done a great deal to beautify the Ottawa-Hull region and to enable its residents to enjoy recreational activities all year round. In the winter, skating on the canal replaces the sight-seeing boats and canoes that are so common in summer months.

Every winter the NCC spends some \$140,000 for maintenance of the canal rink. It has improved the quality of the ice and has added services for the public each season. To keep the ice in

top condition, NCC has approximately 50 men working in three shifts 24 hours a day, 7 days a week, with an arsenal of equipment: tractors, jeeps with snow blades attached, small hand blowers, large tractor-driven blowers, water pumps, and ice drills.

Six electrically heated change shelters, known as "activity centers," have been built along the sides of the canal. Each contains washroom facilities. In addition, food concessionnaires are located in two of the centers, and skate sharpening services, operated by university students, in another two.

As the person in charge of the canal rink, W.E. Taylor gets particular enjoyment from seeing skaters of all ages—toddlers on their first pair of skates, parents with babies papoose-like on their backs, and even some in their 80s—on the ice.

Mr. Taylor, district superintendent for the NCC, estimates that between 75 and 100 persons, many carrying briefcases and lunch bags, skate to and from work or school each weekday. Students and professors on their way to the University of Ottawa and to Carleton University, and businessmen are among the morning "rush hour" crowd on the canal. According to Mr. Taylor, "it is fascinating to see the automobile traffic (on the Driveway along canal) crawling, and the skaters passing it."

Ms. Dworkin is a graduate of the Carleton University School of Journalism. She is editorial assistant, *The Canadian Nurse*.

In contrast, evenings and weekends on the canal have more of a carnival spirit, complete with music and often costumes. At night, strings of grape-fruit-shaped lights across each shelter and along the canal walls contribute bright blues, yellows, reds, and greens to the scene. On weekends throughout the winter, skate-a-thons, city carnivals, and private skating parties are scheduled through the NCC.

#### Safety precautions taken

So far there have been no serious skating accidents. The NCC does not permit snowmobiles on the ice, and restricts hockey playing on weekends — it is not allowed after 12:00 noon. Also, the 37 sets of stairs, which lead to the canal from The Driveway, are covered with woven, coco matting to prevent people from falling on them.

Although the water is drained out of the canal in winter, it can remain deep in places. The NCC continually tests the ice to make sure it is thick enough for safe skating. On warm, sunny days the ice tends to soften in the afternoon.

Since the winter of 1972-73, St. John Ambulance has been involved in training skate patrollers and providing first-aid services. University students, hired to patrol the rink, receive the 16-hour, St. John course. With this senior-level training, they take turns patrolling the rink from 4:00 P.M. to midnight on weekdays and from 9:00 A.M. to midnight on weekends and holidays.

On the weekends, St. John Ambulance members man the posts in the two activity centers, where splints,

DECEMBER 1973



You don't have to skate to enjoy the scenery and fresh air on The Driveway that overlooks the canal. From the popular walking paths on both sides of the canal, passers-by and their pets get a panoramic view of the action on the ice.

There's nothing like a hockey game for many of the boys who skate on the canal. The NCC patrols the rink to make sure the rules are kept. Hockey is not allowed after noon on Saturdays and Sundays.





This is where the skating begins on Ottawa's Rideau Canal. With the National Arts Centre on the left and the Parliament Buildings providing the backdrop, skaters can enjoy the charm of the city from the seclusion of the ice. This is also a good meeting place for friends. A few blocks further down the canal is CNA House.

stretchers, and many other supplies are kept. The red-uniformed skate patrollers carry a large first-aid kit with them on the ice.

About 55 accidents were reported during the 1972-73 winter. These included sprained ankles, ice cuts, and fractured hips, legs, ankles, wrists, and arms. Skaters of all ages have accidents, although the young tend to get only bruises and minor cuts.

#### Similar rinks elsewhere

Mr. Taylor, who has traveled across Canada in his work with the NCC, points out that two similar rinks exist in other parts of the country. One is in Wascana Center, Saskatchewan — just outside Regina. The other is in St. John, New Brunswick.

For those fortunate to be within reach of these rinks, the skating season is never long enough. Despite watering eyes and running noses, skaters manage to forget the cold. As Mr. Taylor says, "I often see skaters carrying wine casks, and I don't believe there is ginger ale in them."

Here I come! Well-bundled and ready to go, this three-year-old gets some help from his parents. Like many other children in Ottawa, he is learning to skate on the canal. Many older children are brought to the rink in school groups during the week.

## A diabetic teaching tool

There are at least 300,000 known diabetics in Canada, and possibly another 300,000 as yet undiscovered. Success in the treatment of these individuals depends on the health teaching they receive. The author devised and tested a Diabetic Teaching Tool, which any nurse can use to facilitate her patients' learning.

Judith M. Skelton, M.Sc.N.

The prevalence of diabetes mellitus is rising throughout the world, according to morbidity and mortality statistics. A number of reasons have been suggested to explain this trend:

Life expectancy in general is increasing; therefore, more diabetics are being diagnosed.

Improvements in medical care not only have lengthened the lifespan of older diabetics, but also have allowed younger diabetics to marry and bear children, thus increasing the number of infants with an inherited predisposition to the disease.

☐ Obesity, thought to be a predisposing factor in the development of diabetes, is also increasing.

The reported relationships between diabetes and other etiological variables have led to earlier detection of many cases. 1

Whatever the causes, the result is an urgent situation. There are at least 300,000 known diabetics in Canada, and possibly another 300,000 as yet

undiscovered. Success in the treatment of these individuals depends, to a large extent, on the caliber of health teaching they receive. And the caliber of health teaching, in turn, depends on effective planning and implementation by health professionals.

Unfortunately, most diabetic health education in Canada can still be characterized as unplanned and hit-or-miss. The following quotation illustrates this graphically:

"... There's the old syringe and orange bit, and then the supervised self-injection, of course — but most other aspects like skin care, cutting nails, respiratory infection, etc., etc., are more or less left to chance. There is no organized or even suggested pattern of introducing these to the patient or, I might add, of ensuring that they are even mentioned . . . " \*

This type of situation must not be allowed to continue! What are the alternatives?

Over the years many diabetic teaching aids have been developed. The list includes books and pamphlets, record-

Ms. Skelion, a graduate of the basic degree program at McMaster University school of nursing, received a master's degree in nursing from the University of British Columbia. She is presently a faculty member of the UBC school of nursing.

<sup>\*</sup> Excerpt from a letter written to the author in response to a request for a description of the diabetic health teaching program of a metropolitan hospital.

ings, films, and programmed learning packets. Much of this material fails to meet the learning needs of the average diabetic.

The reasons for this have been clearly identified by Thrush and Lanese, who state:

"If the patient is to benefit from printed aids, he must be able to understand them. Unfortunately, all too often this is not the case. Instructional material is misinterpreted, misunderstood, or confused because authors fail to write understandably and readers are unable to read with adequate comprehension." 2

This observation is applicable to audio and visual aids, as well as to printed matter.

Organized classes, usually conducted in a general hospital setting, are widely used for education of diabetic patients. Advocates of such classes point out that "in addition to practicality... group sessions have the advantage of group interaction and communication among persons with the same condition."3 One wonders, however, whether other variables — such as the size of class, the interest and expertise of the health professionals doing the teaching, and the fact that a patient may miss one in the series of classes due to some other hospital procedure - may not be significant in judging the relative merits of class-type instruction.

"Diabetic clinic" is a rather broad term that has been applied to a wide spectrum of teaching facilities. Such clinics range from sophisticated in- and outpatient services, such as those at Boston's New England Deaconess Hospital, to the more familiar, general hospital outpatient clinics that serve diabetics by meeting problems as they arise. Diabetic clinics may be effective vehicles of patient education if they are well planned, well funded, and competently staffed.

Diabetic home-care programs—geared to make sure that "the patient with diabetes and his family know what care he will need at home, what precau-

TABLE 1
Comparison of Control and Experimental
Part-Scores on Test of Diabetic Learning

	Possible	Cont	rol	Experin	nental
	marks	range	mean	range	mean
1. Knowledge Subtests a) insulin users b) pill users 2. Skill Subtests a) diet planning b) urine testing c) insulin injecting	75	30.0-69.5	51.75	44.0-64.5	56.95
	70	13.5-57.0	31.30	40.0-62.5	52.15
	20	3.0-16.0	9.85	13.5-18.5	16.30
	10	0.0-8.0	4.40	3.5-10.0	6.75
	11	3.5-9.0	7.20	8.0-11.0	9.50

tions he must observe, and what general health measures should be followed"4— are among the services currently provided by many public health nursing agencies. Here again, planning and staffing are the keys to success.

Diabetic day-care centers, a relatively new development in Canada, are founded on the premise that diabetic teaching is best conducted by a coordinated team of interested and knowledgeable doctors, nurses, and dietitians. Such centers show real promise for comprehensive instruction and follow-through.

However, it is important to be realistic. At present, the number of diabetic day-care centers in Canada is far from adequate to meet the teaching-learning needs of 300,000 diabetics. Until this situation changes, every doctor, nurse, and dietitian must assume responsibility for ensuring that diabetic patients have knowledge and skills they need to manage their own care on a day-to-day basis.

#### Teaching tool

How can this be accomplished? One alternative is a "Diabetic Teaching Tool." The tool described in this article is a teaching aid that can be used by any graduate nurse, in any setting, to guide and facilitate the learning of her

diabetic patients. The two basic components of the tool are: a stand-up binder and a carrying case.

The easel binder is sized for use on an overbed table. The materials in the binder — posters and nurses' instructions — deal with the 11 major content areas of diabetic learning: diet, urine testing, action of insulin and other hypoglycemic agents, technique and sites for insulin injection, care of equipment, symptoms of hypoglycemia, symptoms of uncontrolled diabetes, care of the feet, what to do in case of acute complications, when to consult health professionals, and how to balance exercise and activity with insulin. 5,6

The carrying case contains Kardex slips, lists of diabetic supplies, consent forms, meal-planning booklets, urinetesting kits, patient take-home folders, and a supply of 8½ "x11" pages with content corresponding to that presented in the easel binder. Prescription-type format is incorporated on several of these pages to allow information to be individualized to the patients' interests, needs, and level of clinical control.

In developing the Diabetic Teaching Tool, every attempt was made to gear it to the learning needs of the average diabetic patient. The Dale-Chall readability formula 7 was used, in conjunction with Thrush and Lanese's list of

**DECEMBER 1973** 

unfamiliar words relating to diabetes,8 to keep the reading level at or about Grade Six. Abundant use was made of illustrations and diagrams.

#### **Evaluation**

To evaluate the effectiveness of the Diabetic Teaching Tool, I conducted an experimental study that compared the knowledge and skills of two groups of diabetic patients admitted to a suburban general hospital. The 20 subjects who comprised the control group of the study were taught in an unplanned manner, based on whether and/or what instructions were deemed pertinent by their nurses.

The Diabetic Teaching Tool that I designed was used by each patient's own nurse(s) to instruct the 20 patients in the experimental group. I visited each of the 40 subjects after his discharge from hospital and administered a test of diabetic learning, consisting of a number of short-answer questions and a three-part skill test.

Demographie and diabetic data were recorded for each patient: age, sex, marital status, occupation, education, reason for current hospital admission, time elapsed since most recent previous hospital admission, age at onset of diabetes, duration of diabetes, and type of clinical control. In all these respects there was a high degree of similarity between the control and experimental patient groups.

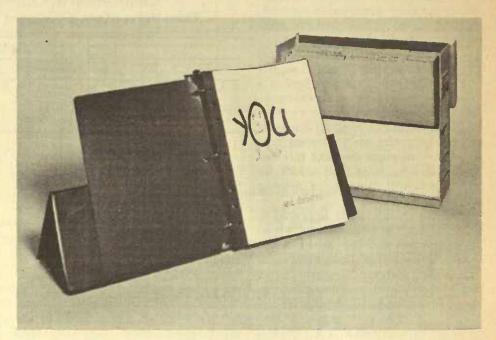
The differences between control and experimental scores on the test of diabetie learning are given in Tables 1 and 2.

Almost all these differences are statistically significant at the .05 level or better.

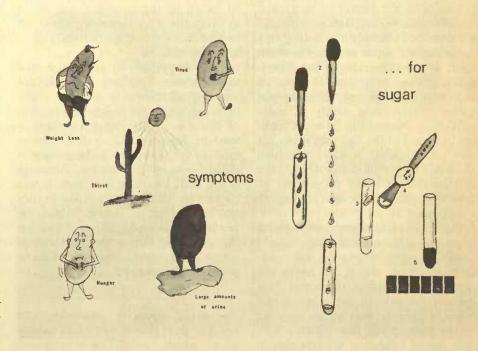
#### **Implications**

These findings have several implications for nurses likely to be interacting with diabetic patients.

The low test scores achieved by patients in the control group of this study suggest that the unplanned, hit-or-miss diabetic teaching provided in many set-



The two parts of the diabetic teaching tool are an easel binder and a carrying case for lesson material.



Posters from the diabetic teaching tool illustrate symptoms of diabetes, left, and testing urine for sugar, right.

tings does not satisfy patients' learning needs for self-care at home. Therefore, nurses currently employed in such settings would do well to consider other means of diabetic patient teaching.

The test scores achieved by patients in the experimental group suggest that the Diabetic Teaching Tool is a useful aid to nurses in providing instruction for diabetics.

Therefore, nurses currently employed in settings giving an unplanned type of instruction might consider this tool as one alternative in their search for more successful methods of diabetic patient education.

Patients in this study appeared to benefit from the planned type of instruction provided by the Diabetic Teaching Tool, regardless of the duration of their diabetes. So, nurses cannot safely assume that patients with long-standing diabetes are knowledgeable and/or skillful in managing their diabetes at home. Rather, each contact with a diabetic patient ought to be viewed and used by the nurse as a teaching opportunity.

The level of learning demonstrated by patients in the control group showed a high negative correlation with age at the time of teaching and testing, that is, the older the patient, the lower the score. This was not true of the experimental group, suggesting that nurses may have internalized society's bias against the learning ability of older individuals. Nurses should be aware of this bias, and of the fact that it has not been substantiated in adult education research. 9 They should, therefore, make a wholehearted effort to provide instruction to all diabetic patients, regardless of age.

The level of learning demonstrated by patients in the control group showed a high positive correlation with previous education, that is, the higher the education, the higher the score. This was not the case in the experimental group, suggesting that nurses may act on the assumption that patients with little formal education are less able to learn adequate diabetic management than patients with more schooling. Rather than omitting or diluting dia-

TABLE 2
Comparison of Control and Experimental
Total Percentage Scores on Test of Diabetic Learning

	177	Insulin Users		Antidiabetic Pill Users		
		Control	Exper.	Control	Exper.	
Percentage	low high mean	37.2 86.6 64.79	65.4 87.1 77.88	20.5 71.5 43.40	57.5 84.5 74.05	

betic teaching for patients with little formal education, nurses should attend to alternate ways in which the knowledge and skills could be presented.

The level of learning demonstrated by patients in the control group showed a high negative correlation with age at onset of diabetes, that is, the younger the patient was when his diabetes was diagnosed, the better his score. This effect was much less marked in the experimental group, suggesting that nurses may put forth a greater effort to teach patients whose diabetes is diagnosed at an early age than those diagnosed later in life. Nurses must be aware of this tendency and strive to overcome it by increasing the effort expended on the diabetic teaching of older individuals.

It is important to emphasize that the Diabetic Teaching Tool is not proposed as a miracle solution to the problems facing the prospective teacher of diabetic health. Other variables — teacher, learner, and environment — must be considered in making diabetic patient education a success. Although I was well aware of this fact, it was beyond the scope of this study to control these factors. It was hoped the results of this research might indicate the utility of such a tool for settings where more highly organized diabetic programs do not exist.

The writer wishes to acknowledge the research grant provided by Miles Laboratories, which funded this investigation. Sincere thanks are also extended to Dr. Margaret Campbell and Ms. Mary Cruise, the researcher's thesis committee.

#### References

- 1. Ellenberg, Max and Rifkin, Harold. Diabetes mellitus: theory and practice. Toronto, McGraw Hill, 1970, p.590.
- 2. Lanese, Richard R. and Thrush, Randolph S. Measuring readability of health education literature. *J. Amer. Diet.* Ass. 42:3:217, Mar. 1963.
- 3. Nickerson, Donna. Teaching the hospitalized diabetic. *Amer. J. Nurs.* 72:5: 938, May 1972.
- 4. Gould, Gertrude and Golden, Jean. Teaching the diabetic at home. *Amer. J. Nurs.* 57:9:1170-71, Sep. 1957.
- Hamwi, George J. Special announcement: treatment of diabetes. *JAMA* 181:1064, Sep. 22, 1962.
- Ellis, Edward Vernal, A comparative analysis of good, poor and very poor control diabetic patients as a basis for determining their educational needs. Chapel Hill, N.C., 1964. (Thesis— North Carolina) p.150.
- 7. Dale, Edgar D. and Chall, Jeanne S. A formula for predicting readability. *Educ. Res. Bull.* 27:11-28, Jan. 1948.
- 8. Thrush, Randolph S. and Lanese, Richard R. The use of printed material in diabetes education. *Diabetes* 11:2:132, Mar./Apr. 1962.
- 9. Adult Education Association of the U.S.A. Adult education: theory and method. Psychology of the adult. Washington, 1967, p.5.

## The Canadian Nurse

50 The Driveway, Ottawa K2P 1E2, Canada



## Information for Authors

#### **Manuscripts**

The Canadian Nurse and L'infirmière canadienne welcome original manuscripts that pertain to nursing, nurses, or related subjects.

All solicited and unsolicited manuscripts are reviewed by the editorial staff before being accepted for publication. Criteria for selection include: originality; value of information to readers; and presentation. A manuscript accepted for publication in *The Canadian Nurse* is not necessarily accepted for publication in *L'infirmière Canadienne*.

The editors reserve the right to edit a manuscript that has been accepted for publication. Edited copy will be submitted to the author for approval prior to publication.

## **Procedure for Submission of Articles**

Manuscript should be typed and double spaced on one side of the page only, leaving wide margins. Submit original copy of manuscript.

#### Style and Format

Manuscript length should be from 1,000 to 2,500 words. Insert short, descriptive titles to indicate divisions in the article. When drugs are mentioned, include generic and trade names. A biographical sketch of the author should accompany the article. Webster's 3rd International Dictionary and Webster's 7th College Dictionary are used as spelling references.

## References, Footnotes, and Bibliography

References, footnotes, and bibliography should be limited **DECEMBER 1973** 

to a reasonable number as determined by the content of the article. References to published sources should be numbered consecutively in the manuscript and listed at the end of the article. Information that cannot be presented in formal reference style should be worked into the text or referred to as a footnote.

Bibliography listings should be unnumbered and placed in alphabetical order. Space sometimes prohibits publishing bibliography, especially a long one. In this event, a note is added at the end of the article stating the bibliography is available on request to the editor.

For book references, list the author's full name, book title and edition, place of publication, publisher, year of publication, and pages consulted. For magazine references, list the author's full name, title of the article, title of magazine, volume, month, year, and pages consulted.

## Photographs, Illustrations, Tables, and Charts

Photographs add interest to an article. Black and white glossy prints are welcome. The size of the photographs is unimportant, provided the details are clear. Each photo should be accompagnied by a full description, including identification of persons. The consent of persons photographed must be secured. Your own organization's form may be used or CNA forms are available on request.

Line drawings can be submitted in rough. If suitable, they will be redrawn by the journal's artist.

Tables and charts should be referred to in the text, but should be self-explanatory. Figures on charts and tables should be typed within pencil-ruled columns.

The Canadian Nurse

OFFICIAL JOURNAL OF THE CANADIAN NURSES' ASSOCIATION
THE CANADIAN NURSE 39

## in a capsule

Are your plants toxic?

Philodendron, poinsettia, and dieffenbachia have more in common than being popular house plants. They are a few of the more familiar toxic plants that can harm a person by causing stomach and intestinal irritation, systemic poisoning, mouth and throat lining irritation, and skin irritation.

This cheerful news comes from the federal department of consumer and corporate affairs. The May issue of its publication Consumer Contact carried

the following advice:

- Teach children how to recognize the most common poisonous plants, such as poison ivy. Tell them not to eat unknown plants or suck plant nectar, and not to play with plants. Keep plant seeds and bulbs away from small children.
- Learn about the plants in your area that could cause harm.
- Don't eat wild plants, including mushrooms, unless you are sure of their identity and safety.
- Don't brew home-made medicines from plants.

Many of the forest and field plants listed as toxic sound dangerous. Who would knowingly collect a "deadly amanita," a "death camas," or a "poison hemlock"? It's much harder to imagine that the buttercup, lily-of-the-valley, hyacinth, sweet pea, or daffodil can be poisonous.

Even the vegetable garden has its hazards: the potato (new shoots) and rhubarb (leaf blade) appear on the com-

mon toxic plant list.

#### Travelers warned

Canadians who travel abroad should be extremely cautious about buying medicines in other countries.

Health and Welfare Minister Marc Lalonde advised Canadians in July that some remedies sold in other countries without a prescription contain drugs that can harm the user and damage the fetus in a pregnant woman.

Even prescription drugs can be dangerous, as they often vary in potency and quality in different countries. Travelers should carry an adequate supply

and a typewritten prescription giving the brand and generic name of the medicine they use, including the dosage.

In some countries, injections are given in pharmacies; Canadians are advised to refuse these because the equipment might not be sterile.

New technique helps children

Doctors at The Hospital for Sick Children in Toronto have developed a new technique that makes test procedures safer and simpler for children with heart defects.

The technique involves injecting a harmless radioactive substance into the patient's bloodstream. The patient lies under a gamma camera, which converts radioactive particles into visible, measurable flashes of light. The camera is connected to the hospital's computer system and can follow the pattern of the circulation, perform calculations, and produce data on a television screen.

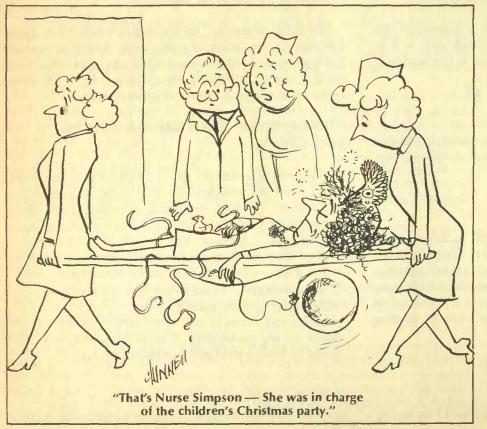
In many cases, this test will replace cardiac catheterization, which involves the hazards of any invasive technique, is particularly difficult to perform on a newborn child, and can only be done a limited number of times on a patient.

This new application of nuclear medicine and computer science has taken two years of research and preparation. By the end of 1973, heart patients at the hospital will be taking the gamma camera test. Some 7,000 to 8,000 patients are handled by the cardiology department each year.

Inside dope

The Canadian registry for prenatal diagnosis of genetic disease, located in the department of pediatrics at Queens University, has reported information collected in its first year. The reasons for amniocenteses performed from April 1, 1972 to March 31, 1973 were: maternal age 69, Down's syndrome 55, other chromosomal abnormalities 13, biochemical deficiencies and known enzyme abnormalities 7, sex linked conditions 8; 12 cases were not coded in the 180 questionnaires returned to the registry.

The findings are reported in the June 1973 Prenatal Diagnosis News-letter, put out by the Medical Research Council.



### names

Jean E. Browne Thomson, a leader in nursing and education, died October 7, 1973, after a long lifetime of service.

Ms. Thomson, who had studied nursing in Toronto and London, England, became the first director of school health work for the Regina School Board in 1911. She organized the first school hygiene branch for the Saskatchewan department of education in 1917. She served as the first president of the Saskatchewan Registered Nurses' Association from 1917 to 1919, and again from 1921 to 1922. She was president of the Canadian Nurses' Association from 1922 to 1926.

Ms. Thomson had a lasting interest in the Red Cross Society, in 1922 becoming the first director of the Canadian Junior Red Cross. She enjoyed international recognition, and received many honors, including the Florence Nightingale medal.

Allan Rosky (R.N., St. Boniface General Hospital school of nursing; B.N., U. of Manitoba), has been appointed associate employment relations adviser of the Manitoba Association of Registered Nurses.

Mr. Rosky has included general duty and intensive care nursing and teaching in his nursing career. He has been involved in collective bargaining, has been vice-president of District 1, MARN, and president of the registered nurses' association of St. Boniface General Hospital.

The Registered Nurses' Association of Ontario has reorganized its employment relations department. Among its new members are: Larry Robbins (M.A., U. of Toronto) who will negotiate contracts and serve associations in Eastern Ontario; Rita Kohan, research officer, who will prepare model contracts and research material and organize the department's reference library; Dan Anderson, grievance officer, who will advise and assist nurse representatives regarding grievances, in addition to his association treasury work; and Yvonne Trower, education officer, who will develop an employment relations educational program and be responsible for the newsletter of the RNAO employment relations department.

**DECEMBER 1973** 



The Middlesex-London District health unit held a dinner in honor of Lenna Richardson on her retirement as supervisor of public health nursing of the unit. Ms. Richardson, center, accepts a presentation from Elizabeth Findlay, right, as Dorothy Mumby, left, director of public health nursing, looks on. Ms. Richardson, a graduate of the Hamilton General Hospital school of nursing, with diplomas in public health nursing and in supervision and administration, has devoted her career to the public health field. She served in Trail, B.C.; Wellington County, Stratford, and Owen Sound, Ontario, prior to joining the Middlesex County health unit in 1969.

Several new members have been appointed to the teaching staff of the school of nursing of Queen's University, Kingston:

Ann Brown (R.N., Royal Victoria Hospital school of nursing, Montreal; B.N., McGill), as lecturer, half-time, in medical-surgical nursing. Ms. Brown has been a staff nurse, assistant and head nurse at the Royal Victoria Hospital

Sally Chestnut (R.N., Victoria General Hospital school of nursing, Halifax; B.N., McGill) as lecturer in medical-surgical nursing. Ms. Chestnut has been staff nurse at the Isaac Walton Killam Hospital, Halifax, The Montreal General Hospital, and the Child Health Association in Montreal.

Heather Locking (R.N., Toronto General Hospital school of nursing;

BNSc., U. of New Brunswick), as lecturer in medical-surgical nursing. Ms. Locking has been on staff at the Toronto General Hospital since graduation.

Barbara Martin (R.N., Wellesley Hospital school of nursing, Toronto; BNSc., U. of Western Ontario), as lecturer in psychiatric nursing. Ms. Martin has been a staff nurse at the Clarke Institute of Psychiatry in Toronto.

Wendy McKnight (R.N., Ottawa Civic Hospital school of nursing; B.N., McGill), as lecturer in nursing. Ms. McKnight has been a staff nurse at the Ottawa Civic Hospital.

Ellen McCarthy (B.Sc., St. Francis Xavier U.; B.D., U. of New Brunswick; M.Sc. (Nutrition), U. of Guelph), as lecturer in nutrition, half-time, at Queen's University and dietitian in the

THE CANADIAN NURSE 41

#### names

ambulatory clinics at Kingston General Hospital.

Heather Ogilvie (R.N., The Hospital for Sick Children school of nursing; BNSc., U. of Western Ontario; M.Sc.N. candidate, U. of Buffalo, N.Y.), as lecturer in nursing of children. Ms. Ogilvie has taught at Timmins Hospital school of nursing and has been a flight sister in the Armed Services.

Allison Sayers (R.N., Atkinson School of Nursing, Toronto Western Hospital; BNSc., U. of Western Ontario), as lecturer in community nursing. Ms. Sayers' experience includes staff nurse with the Victorian Order of Nurses and Department of Health in Toronto; staff nurse at Toronto Western Hospital; clinical instructor at Atkinson School of Nursing; research assistant in the School of Hygiene, University of Toronto; and supervisor, Canadian National Institute for the Blind in Newfoundland.

Lola Zagrodney (R.N., Atkinson School of Nursing, Toronto Western Hospital; BNSc., Queen's U.), as lecturer in community nursing. Ms. Zagrodney was previously public health liaison nurse at Rockwood division of the Kingston Psychiatric Hospital.

Pat Dalenger (R.N., Winnipeg General Hospital school of nursing; B.N., U. of Manitoba), is nursing consultant in family planning with the Alberta Department of Health.

Ms. Dalenger, currently working toward her bachelor of pedagogy, has taken courses in education and in human sexuality. Her nursing career has been devoted to public health and teaching.

Dorothy Lambeth (Reg.N., B.Sc.N., M.A.) has been appointed chairman of the new department of nursing at Mohawk College, Hamilton, Ontario, effective October 1, 1973.



Ms. Lambeth, formerly coordinator of academic and applied arts parttime programs at Scarborough's Centennial College, will head a department comprising more than 800 stu-

dent nurses and nearly 200 staff of the four area schools of nursing, which became part of Mohawk September 1. The Hamilton Civic Hospitals school of nursing, the St. Joseph's school of nursing, the Hamilton and District

school of nursing, and the Brantford General Hospital school of nursing will be known as Mohawk College campuses within the department of nursing.

The four campuses of the department of nursing of Mohawk College are headed by: Mary C. Howey at Brantford General Campus; Virginia Frere at St. Joseph's Campus: Elisabeth M. Maus at Chedoke Campus, and Margaret P. Morgan at Hamilton Civic Campus.



Bessie Lucas (Reg. N., Psychiatric Hospital, London; Cert. Nursing Educ., U. of Toronto) has recently retired from the staff of the Psychiatric Hospital in North bay, Ontario. Her career has largely

been devoted to teaching nursing assistants and affiliate nursing students at the psychiatric hospitals of London, Kingston, and Port Arthur, Ontario.

Ms. Lucas plans to resume active participation in music and studies in philosophy and psychology.





Margaret Francis

Louise Briston

New appointments to the school of nursing, Dalhousie University, Halifax, Nova Scotia, have been announced:

Margaret Rose Francis is associate professor. Dr. Francis has for serveral years been assistant professor at the school of nursing, University of British Columbia, Vancouver, B.C.

Louise Leffert Bristow is assistant professor. She has recently completed her course work toward a doctorate in education at Teachers College, Columbia University, New York City.

Mona June Horrocks is assistant professor. During the past 10 years she has studied and worked in a variety of settings, and along the way earned an M.S. in both psychiatric nursing and community health nursing at the University of California, San Francisco.

Sister Frances McKiernan is assistant professor. Her most recent position has been that of director of nursing service at the Halifax Infirmary, Halifax.

Denise Mary Power is assistant professor. Her most recent appointment has been that of supervisor of clinical

nursing at Victoria General Hospital, Halifax.

Eileen Dauphinee Irwin is community health nursing clinical instructor. For several years prior to resuming her recent studies, Ms. Irwin was with the Victorian Order of Nurses in Halifax.

Susan Elizabeth MacNeilt, who earned her bachelor of nursing degree at Dalhousie University in 1972, is clinical instructor in pediatrics.

Ann Margaret Winter Nielsen is clinical instructor. Ms. Nielsen has been psychiatric nursing instructor at the Nova Scotia Hospital in Dartmouth.

The New Brunswick Association of Registered Nurses has announced that nursing scholarships valued at \$500 each have been awarded to: Louisa lane Armstrong, R.N., Saint John (NBARN St. John Chapter scholarship) for study in the degree program for registered nurses at U. of New Brunswick; Des Ange McGraw, Tracadie (NBARN scholarship) for basic nursing program at U. of Moncton; Rosa McGraw, Robichaud (NBARN scholarship) for basic nursing program at U. of Moncton; Tina Orser McLellan, R.N., Hartland (Muriel Archibald Scholarship) for the degree program for registered nurses at UNB; Susan Plume, Stanley (Dr. Katherine MacLaggan Memorial Scholarship) for basic nursing program, UNB; and Noella Simard, Moncton (Muriel Archibald Scholarship) for basic nursing program, U. of Moncton.

The Division of Tuberculosis Control, Department of Health and Social Development of Alberta, has announced the appointment of A. Viola Flanagan to the position of nurse consultant.

Ms. Flanagan (R.N., Medicine Hat General Hospital school of nursing; B.Sc.N., U. of Alberta) will provide liaison with provincial health units, municipal nurses, federal government nursing stations, and other field units. She will also assist in organizing and conducting educational programs in tuberculosis and respiratory diseases.

Laura Smith (R.N., St. Paul's Hospital, Saskatoon; R.P.N., Saskatchewan Hospital, North Battleford) has joined the staff of the North Okanagan Mental Health Centre in Vernon, B.C. As mental health nurse, she will act as consultant to other professional agencies and will work closely with the department of human resources and the Canadian Mental Health Association.

Ms. Smith's career has embraced psychiatric, public health, and office nursing, as well as teaching psychiatric

nursing.

St. Joseph's Hospital, Guelph, has announced two administrative appointments: Viola Aboud as assistant executive director, and Patricia Valeriote as director of patient services.







Patricia Valeriote

Ms. Aboud (R.N., Montreal General Hospital school of nursing; Dipl. teaching and supervision, McGill U.; Dipl. H.A., School of Hygiene, Toronto) was, for several years, special assistant to the director of nursing and chairman of the nursing procedure committee at the Montreal General Hospital and, later, director of nursing at the Toronto General Hospital.

Ms. Valeriote (B.Sc.N., U. of Western Ontario) previously held positions of administrative assistant and director of nursing at St. Joseph's Hospital,

Guelph.

Alma Elizabeth Reid was appointed acting director of the nursing school at Laurentian University, Sudbury, following the resignation of Dr. Margaret Lee. Professor Reid had been director of the school of nursing at McMaster University, Hamilton, for 21 years prior to retiring in 1970, and has served a term of office as president of the Registered Nurses' Association of Ontario.

More recent appointments to the faculty are: Carolyn O'Connor, formerly of Sudburv Regional School of Nursing; Audrey Pickard, a former lecturer at Laurentian; and Mary Donato, who is with the Sudbury and District Health Unit. The latter two are serving on a

part-time basis.

Phyllis M. Robinson has been named director of nursing education and Lucinda Broadbent, assistant director of nursing education, for the final year of operation of the Calgary General Hos-

pital school of nursing.

Ms. Robinson (R.N., Calgary General Hospital school of nursing; Dipl. Teaching and Supervision, U. of Toronto; B.S.N., U. of British Columbia, Vancouver; M.N., U. of Washington, Seattle) has worked at the Calgary General Hospital during most of her career. She has been staff nurse, supervisor, teacher in maternity nursing, and assistant director of nursing education.

Ms. Broadbent (R.N., Calgary Gen-

eral Hospital school of nursing; Dipl. Public Health Nursing, U. of British Columbia; B.Sc.N., U. of Alberta) has worked with the Victorian Order of Nurses in Prince Albert and in Brampton, Ontario, and has been on the faculty of the Calgary General Hospital school of nursing since 1964.

New faculty appointments at the University of Alberta School of Nursing, Edmonton, have been announced:

Amy Elliott Zelmer is coordinator of continuing education for nurses. Dr. Zelmer has been engaged in public health and health education in Yarmouth and Halifax, N.S., and in Edmonton. More recently, she has been with the department of extension of the U. of Alberta.

Kay A. Dier is assistant professor (nursing director of nurse practitioner program). Ms. Dier has been with northern medical services in Edmonton, Northwest Territories, and Yukon; on the faculty of U. of Saskatchewan; and with the World Health Organization in Iran, Ghana, and Malawi.

Jeanette Thelma Funke is assistant professor. Ms. Funke has been lecturer at the U. of Alberta school of nursing.

Gillian L. Brown is lecturer in advanced practical obstetrics. Ms. Brown has been in charge of the nursing station at Island Lake, Man., and has been head nurse, obstetrics, at Fort Churchill General Hospital.

Mary Wood Cannings is lecturer (postbasic). Ms. Cannings has been district nurse with the City of Edmonton

health department.

Eileen Creasey Crane is lecturer. She has worked in Calgary at the provincial cancer clinic, the Southwood Nursing Home, the City Health Department and, as inservice coordinator, at the Bethany Auxiliary Hospital.

Darlene Pollock Forrest is lecturer. She has been instructor at the school of nursing for the past two years.

Linda Isabel Reutter is lecturer in medical-surgical nursing. She has been a clinical instructor at the University of Alberta Hospital and a part-time clinical supervisor in the basic degree program at the U. of Alberta.

Janet Hersberger Smith is sessional lecturer. Ms. Smith has worked at the Royal Alexandra Hospital and the Misericordia Hospital in Edmonton.

Sylvia Thompson (R.N., St. Paul's Hospital, Vancouver) has been appointed director of nursing at Mills Memorial Hospital in Terrace, British Columbia. Prior to joining the hospital staff in 1971, Ms. Thompson had nursed at Queen Charlotte City, Bella Coola, and Bella Bella, British Columbia.

Olive Mercier is director of nursing at the French-language school of nursing in Edmunston, New Brunswick, where a two-year diploma course in nursing began in September 1973.

Ms. Mercier (R.N., Hotel Dieu Hospital school of nursing, Chicoutimi; B.Sc.Inf. and M.A.S., U. of Montreal) can call on her wide experience as a public health nurse and professor of nursing in her present position.

Margaret Risk has been appointed assistant director of nursing at the Borough of East York Health Unit. Associated with these duties, she is developing the role of clinical nurse specialist in a generalized public health program

Ms. Risk (Reg.N., Toronto Western Hospital; B.Sc.N. and M.Sc.N., University of Toronto) has worked in a generalized public health nursing program with the City of Toronto. She has also been a clinical instructor for the University of Toronto school of nursing and a field investigator with Connaught Laboratories.

Sister Cecile Gauthier, has been appointed counsellor to the Mother General of the Grey Nuns of Montreal.



Sr. Gauthier was assistant executive director — nursing at St. Boniface General Hospital, Winnipeg, and a member of the board of directors of the Manitoba Association of Reg-

istered Nurses at the time of her appointment.

Hazel White has just retired as matron of Blunt's Nursing Home at Leduc, Alberta, having nursed for 50 years in Alberta.

Ms. White graduated from the Royal Alexandra Hospital School of Nursing in 1921, and her nursing career has brought her to such places as Innisfail, Lloydminster, Banff, Whitecourt, Hanna, Magrath, Jasper, Mayerthorpe, and Wainwright.

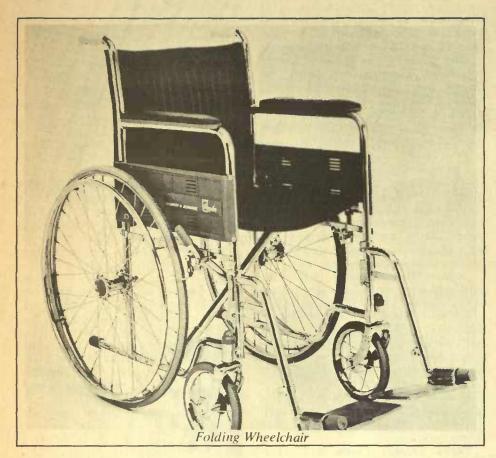
E. Susan Wilson, (R.N., Ottawa Civic Hospital school of nursing; B.Sc.N., University of Alberta), has been appointed charge nurse in family planning for the City of Edmonton local board of health.

Ms. Wilson has had a number of years of experience in hospital nursing and, prior to her appointment, was public health nurse at the Jasper Place Clinic for the City of Edmonton.

THE CANADIAN NURSE 43

## new products

Descriptions are based on information supplied by the manufacturer. No endorsement is intended.



Utility Tray

Aids from Everest & Jennings

Everest & Jennings Canadian Ltd., 111 Snidercroft Road, Concord, Ontario, has announced that its model 1890-S walking aid now has a utility tray available at no extra cost. This grey plastic tray, which measures 17 5/8 x 4 1/8 x 4 1/8 inches provides a handy storage area for small items.

The walker is made from lightweight, chrome-plated steel tubing and is adjustable in one-inch increments from 32 inches to 36 inches high. Anti-rattle sleeves on the legs eliminate clatter, and a high cross brace allows the walker to straddle standard toilets. Heavy duty nonmarking, nonskidding rubber feet provide maximum safety.

Also available from this company is a folding wheelchair for those who require a wheelchair but still want to travel. Available in standard and narrow adult models, the wheelchair folds to 93/4 inches wide. It is sturdy and can be stored in a car, bus, train, or airplane. Standard features include 24-inch

wheels with 5 - or 8-inch casters, protec-

tive side panels, hubcaps, removable foot plates, padded armrests, safety brakes, and contoured legrest panels.

Kidney equipment

Milton Roy Company, Florida, has announced a new line of home and hospital artificial kidney equipment

and supplies.

The equipment, which was displayed in Boston April 8 and 9, includes a new coil batch system for dialyzing one or two patients, and a continuous preparation system for economically treating up to 30 patients simultaneously.

Features of the new batch-type system, which will accept any coil dialyzer, include a modular concept to conserve floor space, a low canister volume to reduce starting time, and a simplified design for ease of operation, training, and maintenance.

The basic model of the multiple patient system can supply dialysate for up to five patients. Increasing the system's capacity to handle 10 or 20 patients is easy because of its modular design. A backup proportioning system prevents interruption of dialysis schedules.

Accessories for dialysis include a new infusion pump for injecting medication into the blood stream during dialysis, and a fistula training arm for use in home dialysis training programs.

A copy of the new catalog of Milton Roy dialysis equipment and supplies is available on request from Milton Roy Co., P.O. Box 12169, St. Petersburg, Florida 33733, U.S.A.

**Recording Resusci Anne** 

The Recording Resusci Anne is a selfcontained multisensory manikin with an automatic recording system that provides the learner with immediate corrective feedback. Colored lights instantly show the student's progress in learning correct ventilation, sufficient compression, and accurate hand position. An audio rhythm counter helps the student practice a constant and effective rhythm.

A computer-type tape printout shows the student's mistakes; both the amount of ventilation and cardiac compression exerted are signified. The printout also

(Continued on page 46)

## **Double-Tex** Surgeons' Gloves



Need extra protection against slippage when you're handling slippery metal, glass and plastic surgical instruments? Try Perry's Double-Tex\* sterile, surgical gloves with light, velvet-textured palms.

You'll also get another exclusive Double-Tex feature. A special textured interior surface. Designed to protect against "in-the-glove slippage" caused by perspiration build-up during long procedures.

Double-Tex's strong, but thin, palm prevents binding. In addition, specially designed, curved fingers make Double-Tex a comfortable glove that is not fatiguing during long procedures.

Available in white and brown latex. Sizes 5½ through 9. Packaged in convenient peeldown, nonrescalable outerwrap. Innerwrap provides a 276 square inch sterile field. Double-Tex. Just what you asked for and just from Perry.



AFFILIATED MEDICAL PRODUCTS LIMITED
90 Commercial Avenue, Ajax, Ontario

#### new products

(Continued from page 44)

gives the number of times the student faulted on hand placement pressure, and indicates a simulation of the carotid pulse.

The Recording Resusci Anne diagnoses lack of pulse, and dilatation and constriction of the pupils. This batterypowered, life-size manikin is available from Safety Supply Company, 214 King Street East, Toronto, Ontario.

Posey vest

A new product has been introduced by Posey Company. It is a Posey vest with a waist adjustment that the patient cannot change. The waist belt can be adjusted to fit the patient comfortably and can be secured under the bed.

This vest comes in small, medium, and large sizes in cotton or Breezeline. More information is available from Enns & Gilmore Ltd., 1033 Rangeview

Rd., Port Credit, Ontario.

Sterile specimen container

A sterile specimen container with a pouring spout, screw-top lid, and convenient handle has been developed by Sage Products, Inc. This clear plastic container for collecting urine specimens, sputum, stools, and tissue, and for storing microscope slides is marked with a graduated measure in milliliters and ounces. The container's squat design provides stability, prevents tipping, and makes the containers easy to store. It is completely disposable.

The container's screw-top jar closure prevents spilling or accidental contamination; its wide mouth and handle make

it convenient to use.

For further information, write to Ingram and Bell Limited, 20 Bond Avenue, Don Mills, Ontario.



Sterile Specimen Container



Metric fever

With conversion to the metric system close at hand, La Barge Inc. has announced the availability of an electronic thermometer, which reads a person's temperature in both fahrenheit

and centigrade degrees.

According to the company, this is the first and only thermometer that gives both readings simultaneously. It is for use in hospitals, clinics, physician's offices, nursing homes, and family homes. In the conversion of a person's temperature from 98.6 degrees fahrenheit, the centigrade temperature is 37.0 degrees.

For more information about this thermometer, write to La Barge, Inc., 500 Broadway Building, St. Louis, Missouri 63102, U.S.A.

Hemotogene-Sachet

ICN Canada has announced that Hematogene-Sachet is available in a new, reusable plastic box. The box comes with a sliding cover and is divided to contain 24 sachets.

Hematogene-Sachet is a hematinic tonic indicated in cases of iron deficiency anemia and nutritional deficiencies. All data on the product are printed on a sleeve, which can be removed when a pharmacist dispenses this prescribed tonic.

Each sachet contains 10 ml of Hematogene elixir. Further information is available from ICN Canada Ltd., 675 Montée de Liesse, Montreal 377, Ouebec.

Sterilizing envelopes

A new line of sterilizing envelopes, which offer positive heat-sealed bond and no shrinking or curling, has been introduced by Sparta Instrument Corporation.

Called "Asepti-Pak," the envelopes are made of extra heavy plastic lami-nate. It is clear for ready identification of contents and heat-sealed to high grade, wet strength paper on three sides. The envelopes, available in a wide range of sizes, include a chevron for aseptic removal of sterilized con-

Asepti-Pak sterilizing envelopes may be used for steam or gas sterilization. Each envelope is provided with indicator stripes which change color after autoclaving.

Additional information may be obtained from Sparta Instrument Corporation, 305 Fairfield Avenue, Fair-

field, N.J. 07006, U.S.A.

Dopamet

ICN Canada Limited has announced that Dopamet (Methyldopa tablets U.S.P.) is available in Canada. It is indicated in the treatment of sustained, moderate to severe hypertension.

This 250 mg film-coated tablet, which is yellow, comes in bottles of 50 and 500 tablets. One to two tablets, taken two to four times daily, is the recommended

dosage.

For more information, write to ICN Canada, 675 Montée de Liesse, Montreal 377, Quebec.

## dates

#### January 14-18, 1974

Workshop on "Coronary Care and Cardiopulmonary Resuscitation," for nurses who are working in a hospital that has cardiac monitoring equipment, U. of Saskatchewan, Saskatoon. This course is designed to provide instruction in the principles and practice of coronary care and resuscitation. The program will not qualify a nurse to be a specialist without further training. For further information, write to: Norma J. Fulton, Continuing Nursing Education, College of Nursing, U. of Saskatchewan, Saskatoon, Sask.

#### January 21-25, 1974

Workshop on "Tomorrow's Family -Implications for Health," Saskatoon. This workshop is for nursing personnel from community agencies and from obstetric and pediatric units in hospitals, who are working in a coordinating role in group medical practice, and in the nurse practitioner role. The workshop will center on the discussion of the family of the future and implications for a changing response by nurses who have a central role in delivering health care to families. For further information, write to: Norma J. Fulton, Continuing Nursing Education, College of Nursing, U. of Saskatchewan, Saskatoon, Saskatchewan.

#### February 2-9; February 8-15, 1974

Two cultural and professional trips to Portugal, sponsored by the Association of Nurses of the Province of Quebec. ANPQ believes this trip will combine interesting experiences and a restful holiday. Visits to hospitals are included in the program. Cost of the tour is \$299 per person (all inclusive). For further information, contact: Professional Seminar Consultant, Vanier Medical Center, 261 Montreal Rd., Suite 204, Ottawa, Ontario K1L 8C7.

#### February 18-22, 1974

Occupational health nursing program for registered nurses employed in the field of occupational health nursing. Fee: \$95. For further information, write to: Continuing Education Program for Nurses, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ontario.

#### March 1-3, 1974

Orthopedic Nurses' Association, first national congress, Atlanta, Georgia. For further information, write to: Clara A. Donahoo, Executive Director, Suite 705, 1938 Peachtree Rd., N.W., Atlanta, Ga. 30309, U.S.A.

#### April 5-6, 1974

Annual Stewart Research Conference and celebration of the 75th anniversary of the department of nursing education, Teachers College, Columbia University, New York, Fee: \$25. For information and reservations, write to: Dr. M. Louise Fitzpatrick, Chairman, Stewart Research Conference, Box 150, Dept. of Nursing Education, Teachers College, Columbia U., 525 W. 120th, New York, N.Y. 10027, USA.

#### April 29-30, 1974

Ambulatory Pediatric Association, 14th annual meeting, Sheraton-Park Hotel, Washington, D.C. Abstracts are invited to be considered for presentation at the scientific sessions. For further information, write to: E.S. Hillman, M.D., Montreal Children's Hospital, 2300 Tupper St., Montreal 108, Quebec.

#### May 2-4, 1974

Vancouver General Hospital 75th anniversary, gala celebration and alumni banquet, Regency Hyatt Hotel, Vancouver, B.C. For further information, write to: Executive Secretary, VGH Alumni Association, 2851 Heather St., Vancouver 9, B.C.

#### May 5-10, 1974

Third Canadian Operating Room Nurses' convention, The Queen Elizabeth Hotel, Montreal, Quebec. For additional information, write to: Ms. Peggy Iton, c/o Jewish General Hospital, 3755 Cote St. Catherine Road, Montreal 249, Quebec.

#### May 7-9, 1974

Reunion of all Saskatoon City Hospital graduates in Vancouver, Sheraton-Landmark Hotel, Vancouver. For further information, write to: Saskatoon City Hospital Reunion, Box 46355, Vancouver, B.C. V6R 4G6.

#### May 29 - June 1, 1974

Association for the Care of Children in Hospitals, 9th annual conference, Sheraton-Chicago Hotel, Chicago, Ill-inois. Children's Memorial Hospital of Chicago is the sponsoring institution. Conference theme: "Who puts the pieces together?" A pre-conference seminar on play therapy will take place on May 29, 1974. For registration and program information, write to: Myrtha Sice, Recreational Therapy Dept., Children's Memorial Hospital, 2300 Children's Plaza, Chicago, Illinois 60614.

#### lune 16-21, 1974

Canadian Nurses' Association annual meeting and convention, to be held in the Manitoba Centennial Centre Concert Hall, Winnipeg, Manitoba.



#### June 18-21, 1974

Canadian Public Health Association, 65th annual meeting, St. John's, Nfld. Theme: "Patterns of Health Delivery—Rural and Urban." CPHA members and non-members wishing to participate in the scientific sessions should submit abstracts of proposed papers to: Lowell W. Gerson, Ph.D., Chairman, Scientific Program Planning Committee, Faculty of Medicine, Memorial University of Newfoundland, St. John's. Deadline for submission of abstracts is January 15, 1974.

#### June 23-28, 1974

Canadian Medical Association, annual meeting, Toronto, Ontario. For further information, write to: CMA House, 1867 Alta Vista Dr., Ottawa, Ontario. K1G 0G8.

## books

Adult and Child Care: A Client Approach to Nursing by Janet Miller Barber, Lillian Gatlin Stokes, and Diane McGovern Billings. 814 pages. St. Louis, Mosby, 1973. Reviewed by Audrey DeBlock, Lecturer, College of Nursing, University of Saskatchewan, Sąskatoon, Saskatchewan.

This book presents the traditional patient as a client in a variety of settings and situations where nurse involvement is both episodic and distributive. This orientation to the client model and to the health concept places the focus on a growth and development continuum of life and wholeness, as well as on the assets and active involvement of individual and group clients.

The framework for the units is in relation to the recognition and further perception of basic needs, the normal development and meeting of basic needs, the factors that affect the basic needs and cause interferences to occur, and the nursing management that assists the client to a return to the continuum of wholeness.

Though the client approach isn't unique to all nurses, it is unique to the nursing text. The text includes medical-surgical material, and appropriately integrates pediatrics and geriatrics. This is most meaningful for it stimulates the perception of client wholeness where client parts are no longer in the way, obstructing the total view of life. Illustrations show a variety of settings and style.

The charts throughout the text and the appendix, for example those on infectious diseases, can be of great value for ready reference to assist in decision making regarding appropriate nursing intervention. The risk charts lend appeal to the trend to specific problem approaches, such as SOAP. The suggested reading lists at the end of each unit appear to be a wide sampling of authors and subjects, representative of up-to-date, quality articles that are professionally recognized.

This text would be a good acquisition to any professional library. The beauty of its simplistic framework complements the wealth of comprehensive material at hand in one basic reference. A search for item information through the use of the index will produce the

desired information or provide a basis for a further search in depth.

I would highly recommend Adult and Child Care to the contemporary nursing student in particular, for it will definitely assist her "to become," and to all nurses in general, for it will lend direction for nurse involvement in a realistic total health care system.

Intensive Nursing Care, 2ed., by Lenette Owens Burrell and Zeb L. Burrell, Jr. 360 pages. St. Louis, Mosby, 1973.

Reviewed by Cheryl Doiron, Assistant Director of Nursing, St. Joseph's Hospital, Saint John, N.B.

This book was written with the intention of providing essential information for the critical care nurse, physicians outside their area of specialty, medical students, and technicians in ICU, CCU, and the emergency department. It does just that.

It is well organized in its coverage of critical conditions affecting every major system of the body. The reader is provided with a point summary of typical initial treatment, which would be valuable for quick review in emergency situations. The writers then elaborate concisely on clinical findings, pathogenesis, treatment, and patient education.

In spite of the fact that the reader has quick information at his fingertips, this is not a book to be skimmed; no words are wasted on irrelevant or non-essential material. Although brevity is a keynote of this presentation, a ready link is established between nursing action and underlying principles. The authors never instruct the reader to note an observation without telling him, in capsule form, exactly what he is looking for, how it could be interpreted in terms of the patient's condition, and what action should be taken.

Awareness of the total person is evident throughout the book. It is a pleasure to read a text that does not neglect the human element in its attempt to summarize theory. The emotional needs of the patient and his family are stressed as being an important aspect of nursing care; consideration is also given to the reactions of nurses working in critical care areas.

The chapter on electrocardiography and peritoneal dialysis are particularly well done. The authors have also reorganized the section on drugs, so the reader is able to understand their action more clearly in terms of the system affected. The additional chapters on anatomy and physiology of the nervous system and burns present pertinent material, but, like the rest of the book, it is basic in its content, giving simplified explanations of complicated mechanisms.

The authors have not covered any subject in depth, but have accomplished their objective of providing essential information. The text is an excellent source of quick reference and would no doubt act as a stimulus for further investigation.

Psychosocial Nursing Care of the Aged edited by Irene Mortenson Burnside. 214 pages. Toronto, McGraw-Hill Ryerson, 1973.

Reviewed by Peggy Saunders, Assistant Professor, School of Nursing, University of British Columbia, Vancouver, B.C.

In this book the editor has selected and organized 19 nursing papers on psychosocial care under four timely topics. These include communications, the aged patient in the institution, the aged individual in the community, and group work with the elderly person.

Ms. Mortenson points out commonalities of the authors: each places emphasis on psychosocial care of the aged person, all are nurses, and the papers are rich in clinical data. These factors hold great significance in the task of providing individualized health care.

The purpose of the book is to encourage other nurse practitioners to share their findings in this complex field of psychosocial nursing of the aged person, and to gain support through sharing.

A theme running through all the papers is the need for individuals to have some control over the kind of health care they receive, as well as the manner in which it is provided. The editor directs the reader to consider the monumental adjustments the elderly person must make in daily living. Furthermore, the adjustments are made at

a time in life when the individual has fewer physical, emotional, and social resources than ever before.

The section on communication includes some particularly pertinent problems encountered in interviewing. Since the elderly person is subjected to much questioning and may doubt the value of the interview or the sincerity of the interviewer, unique problems arise that require special skills to overcome.

Group work with aged persons is described in the last five papers. This section is of the utmost interest at a time when nurses are becoming more and more involved with groups.

Each section of the book contributes to an understanding of the many areas of concern in psychosocial nursing care of the aged. Nursing students and practitioners alike should benefit from this collection of papers.

Intravenous Medications; A Handbook for Nurses and Other Allied Health Personnel by Betty L. Gahart. 176 pages. St. Louis, Mosby, 1973. Reviewed by Mary C. Stewart, Supervisor, Nurse Technician Department, Ottawa Civic Hospital, Ottawa, Ontario.

The author states in the preface that nursing today embodies many responsibilities that were once the sole responsibility of the physician. One of the new roles is the administration of intravenous medications.

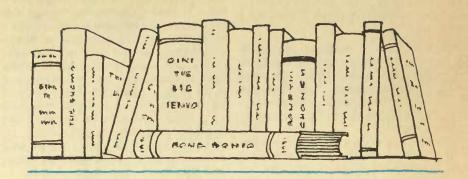
Intravenous medications are potentially dangerous with incorrect use; as a result it is important that all nurses have a clear, concise, and simple form of quick reference.

The drugs in this book are crossindexed by generic and trade names. Each drug has the following information: usual dose, dilution, rate of administration, actions, indications and use, precautions, contraindications, drugs with which it is incompatible, side effects, and antidote.

One advantage of the book is the quick review it affords the nurse, which is particularly valuable for medications that are used infrequently. Another area of value is "Incompatible with"; these are rarely found in the package inserts supplied by the manufacturer, or in the pharmacology books.

A great many factors determine incompatibilities, such as temperature of solutions and rooms, pH of solutions, dilution, and the length of time the drug has been mixed. As a result, there are not always specific incompatibilities listed in this book; the nurse must be alert for signs of incompatibilities.

The information in the book is per-



tinent only to the intravenous use of the drug and is not necessarily pertinent to intramuscular, subcutaneous, oral, or other means of administration.

This book constitutes a well-planned, well-written, accurate working manual for all nurses who are involved with intravenous therapy and the administration of intravenous medication. It can be easily adapted to the requirements of each hospital, specialty area, and allied personnel, as each has a definite protocol regarding administration of intravenous medications. On most pages there is a blank space where pertinent information or special requests of attending physicians could be written, so the book could be incorporated into any existing program.

The Group Approach in Nursing Practice by Gwen D. Marram. 220 pages. St. Louis, Mosby, 1973.

Reviewed by Thelma I. Potter, As-

Reviewed by Thelma 1. Potter, Assistant Professor, Faculty of Nursing, The University of Western Ontario, London, Ontario.

The purpose of this book is to enhance the nurse's ability to function effectively as a group leader, therapist, or co-therapist; to increase the nurse's understanding of groups and group work, enhancing consequences for individuals; and to examine the roles of co-leaders and group members.

No questions are raised in the reviewer's mind about the value of the group interactive process in growth, learning, and change. Nurses are constantly engaged in bringing about ways in thinking, being, and doing among patients with a variety of health-illness problems. Therefore, nurses are active participants in growth-promoting functions.

The author of this book has re-

searched group process as it applies to nursing. The references are impressive. Major aspects of the book deal with co-leaders; leader intervention; various kinds of groups, such as psychotherapeutic, therapy, and self-help groups; and techniques in groups, as well as typing of group behavior.

The author brings together successfully, in conceptual terms, the roles of leader and co-leader; she differentiates distinctively between leadership functions and leadership intervention. She advocates the use of games, improvisations, and exercises to resolve interpersonal problems; these provide a practical base for learning by doing.

She believes the nurse has an active role in therapeutic groups in medical-surgical nursing, in preoperative preparation, in kidney transplant units, in work with schools, unwed mothers, and delinquents. The aged, who have problems of social disengagement and sensory impoverishment, can be helped through group therapy to regain self-respect, to reawaken intellectual pursuits, and to develop capabilities for resuming community life.

The author has achieved the objective of examining co-leader and member roles. Certainly, she has increased the nurse-reader's understanding of the value of group work and group process

in nursing practice.

I question, however, whether the third objective has been achieved, that is, to enhance the nurse's ability to function effectively as a group leader. To achieve this last objective would require involvement in skill-practice as a group leader. In other words, theoretical understanding does not ensure ability in practice; this is particularly true in group work and learning through group process.

One other critical comment is in order. I question the need for and the extent of use of a book such as this one,

#### books

since it is (soundly) based on the works of recognized authorities in the field of educational achievement through group process. Most professionals would prefer to seek out original sources, rather than another's interpretations of them.

The author does impress the reader with the fact that the basic principles and components of group process can be usefully applied in helping patients to cope with adaptation and adjustment needs.

Nursing the Open-Heart Surgery Patient

by Mary Jo Aspinall. 303 pages. New York, McGraw-Hill, 1973. Canadian Agent: McGraw-Hill Ryerson, Scarborough, Ontario.

Reviewed by Joan A. Royle, Lecturer, McMaster University School of Nursing, Hamilton, Ontario.

The author's stated purposes in this book are to assist the nurse practitioner to render skillful nursing care to the patient with open-heart surgery, and to encourage the nurse researcher to explore, test, and evaluate new approaches to nursing care. Although the second purpose cannot be readily evaluated by the reader, the format of this text facilitates the achievement of both objectives by discussing the nurse's role in assessment, intervention, and evaluation of care in relation to underlying theoretical concepts.

Using the nursing process as a framework, the author deals comprehensively with fluid and electrolyte balance and respiratory and circulatory functioning. Assessment of physical symptoms and lab indexes are discussed in relation to their significance for the postoperative cardiac surgical patient. Nursing interventions with underlying rationale are described and summarized at the end of each chapter. Consideration is also given to major complications that may develop following open-heart surgery.

Throughout the book, the author has illustrated the fact that patients' physical and psychological responses are interrelated and of equal importance to the nurse in her assessment and care

of the individual.

Basic physiology, electrocardiology, and surgical techniques are briefly outlined to permit understanding of the underlying rationale for nursing care. Nurses functioning in cardiae surgical units would need to refer to other sources to supplement their knowledge in these areas.

The discussion of pre- and postoperative preparation of the patient and family contains valuable, though somewhat limited, information on an area crucial to the patient's and family's ability to cope with the impact of illness and surgery on their subsequent lifestyles. The importance of continuity of care is recognized by the author, but is not well exemplified in the body of the text. Only token recognition is given to the role and specific needs of the family during each stage of illness.

The material in this book is well documented and is directed to nurses and nursing. It would be of value in assisting nurses caring for open-heart surgical patients in the hospital setting, to further their knowledge, and to enhance their ability to provide purposeful nursing care that meets both the psychological and physiological needs of the individual.

Nursing Care of the Cancer Patient, 2ed., by Rosemary Bouchard and Norma F. Owens. 290 pages. St. Louis, Mosby, 1972.

Reviewed by Bonny Hoyt, Lecturer, Faculty of Nursing, University of New Brunswick, Fredericton, N.B.

The second edition of this book has been updated and several new chapters added, but it still remains a book for nurses written by nurses. The authors see the book as arising from the need of all nurses and related health professionals to have an understanding of the care needed by cancer patients.

The first four chapters cover the history, prevention, detection, and psychological significance of cancer. A good table classifies neoplasms according to their parent tissue and whether they are benign or malignant. In this first part, as throughout, the nurses' role to support the patient and the family receives appropriate emphasis.

In the following three chapters the various types of therapy — surgery, radiation, and ehemotherapy — are discussed. The latter two areas are covered in depth with emphasis on new techniques and drugs. The remainder of the book takes various body areas and systems and shows how these can be affected by cancer and outlines the nursing care involved. These chapters are authenticated by actual patient photographs and many excellent diagrams.

Each chapter is in itself a unit and includes detailed information on the topic. One chapter, for example, "The Nursing Care of the Patient with a Gastrointestinal Disorder," covers such areas as signs and symptoms of dys-

function, malignant tumors, their location and management, aspects of nutrition, nursing management of the patient with abdominal radiation therapy, and the accessory structures of the gastrointestinal tract. Diagrams in this chapter include those of various types of gastrectomies, colostomies, and various methods of colostomy irrigations.

This book is well written and informative and covers an area many nurses find hard to face — the nursing care of the cancer patient. It should be a useful book for all levels of nurses involved with the care of cancer pa-

tients.

Elements of Research in Nursing by Eleanor Walters Treece and James William Treece, Jr. 284 pages. St. Louis, Mosby, 1973.

Reviewed by Sheila Creeggan, Assistant Professor, Faculty of Nursing, The University of Western Omario, London, Ontario.

As the volume of published research increases and more courses are offered to assist nurses in carrying out studies and in critically evaluating and implementing published findings, good reference texts are vital. The present publication represents just such a text, though it is stronger in the area of process than in critical evaluation of published reports.

The authors' stated intention was to write a basic text "aimed particularly at the student enrolled in a baccalaureate nursing program, but appropriate for the graduate student and interest-

ed nurse practitioner."

The style is excellent, terminology familiar to the selected audience is used, and most terms and concepts are defined clearly and concisely. The chapter summaries are succinct and done with a masterful touch. These summaries should serve as references and evaluative tools for the neophyte and others using the book.

The preface states that the book is organized "in the same sequence as a topic would be researched." The book is divided into five parts and, when the scientific method is discussed, it is considered to follow five steps. It would have provided strength to the discussion of scientific method as "process of investigation" if the divisions of the book had been worded as the steps of the process.

Chapter one provides an excellent introduction to purposes and characteristics of research, but the latter half of the chapter, with its review of nursing history and perspectives, adds nothing

The chapter on ethics in research is

an excellent introduction to the topic, and the questions posed related to data gathering provide a good focus for discussion. Some facets are not covered, such as the place of peer review, third party consent, and rights of minors and incompetent persons.

One chapter is devoted to hypotheses, and, though it is stated that "it is not absolutely necessary to have a hypothesis in order to carry out a research study," this section seems incomplete. No assistance is given to stating the research purpose in the form of a declarative statement or question if the investigator has insufficient information on which to make a hypothesis.

Sampling and data collection are adequately covered with both advantages and disadvantages of instruments and approaches discussed. In the part on data analysis, descriptive measures, descriptive and inferential statistics, and parametric and nonparametric methods are discussed simply. The statistical tests referred to are those covered in most introductory statistics courses and should be of assistance to beginning students and to those planning research without a background in statistics, encouraging all to seek guidance about analysis before collecting data.

Emphasis is placed on report writing and publication as a responsibility of the investigator. Many useful hints are provided, including a superb section on table construction, but there is only a brief reference to charts and graphs.

This is a useful addition to the available nursing research texts, and one that will provide valuable guidance for any nurse wanting to learn and begin doing research in nursing.

The Practice of Mental Health Nursing: A Community Approach by Arthur James Morgan and Judith Wilson Moreno. 211 pages. Toronto, Lippincott, 1973.

Reviewed by Jean Bragg, Follow-up Coordinator, Allan Memorial Institute, Montreal, Quebec.

In the introduction, the authors set forth "to think and to interact with the student, to anticipate questions and hesitations, to encourage the student to press ahead where it is safe to do so." They succeed admirably in this venture,

In addition, they manage to dispel the mystique that tends to surround mental and emotional disorders and their treatment. The first chapter on "Professional Jargon" does this with pleasant humor.

I found this text clear, concise, and accurate. Of particular value to the student is the chapter on "The Psychia-

tric Interview." Presenting the nurse with a situation and asking her to consider her responses and feelings brought it to a reality level and also emphasized the critical nature of the first contact between patient and nurse.

The format of the interview is presented in such a way that the nurse knows exactly what to ask and how to ask difficult questions (for example, those related to sex, suicidal thoughts, etc.). It also encourages the nurse to consider her patient as a total person who interacts with many others outside the interview situation and to consider these others in terms of their influence and as a source of information.

"Crisis Intervention" deals with the historical background of crisis and how to deal with a person in crisis. The four stages of crisis development give an excellent picture of what happens to a person.

"Interviewing in Crisis Situations" and the succeeding areas of consideration during such an interview are summarized in point form. This is a useful tool for a fledgling interviewer to remember and use when faced with an upset person.

The discussion of the various disorders in "Diagnostic Impressions" could perhaps have been more detailed, especially involutional melancholia. The references and suggestions for further reading are ample and the nurse should avail herself of them. Psychotherapy and psychopharmacology certainly require more extensive study.

Considering the expanding horizons in nursing and the move toward community care of patients, this is a useful and significant work. It should become required reading for all those involved in treating patients with mental disorders, whether they work within the traditional setting or in community

#### accession list

Publications on this list have been received recently in the CNA library and are listed in language of source.

Material on this list, except reference items, may be borrowed by CNA members, schools of nursing and other institutions. Reference (R) items (archive books and directories, almanaes and similar basic books) do not go out on loan. Theses, also R are on Reserve and may go out on Interlibrary loan

Request for loans should be made

on the "Request Form for Accession List" and should be addressed to: The Library, Canadian Nurses' Association, 50 The Driveway, Ottawa, K2P 1E2.

No more than three titles should be requested at any one time.

#### BOOKS AND DOCUMENTS

- 1. Advice to the expectant mother on the care of her health and that of her child, by J.C. McClure Browne. 14ed. London, Churchill Livingstone, 1973, 61p.
- 2. Analysis and interpretation of Canadian financial statements, by J. Langhout. St. John's, Nfld., University Press of Canada. 1972, 252p.
- 3. The arithmetic of dosages and solutions; a programmed presentation, by Laura K. Hart, 3ed. St. Louis, Mosby, 1973, 76p.
- 4. Basic pharmacology for nurses, by Jessie E. Squire and Jean M. Welch. 5ed. St. Louis. Mosby, 1973, 370p.
- 5. Behavior modification; a significant method in nursing practice, by Michael D. Le-Bow. Englewood Cliffs. N.J., Prentice-Hall. 1973. 271p.
- 6. Bibliography on student services at Canadian universities by the Association of Universities and Colleges of Canada and the Council of Association of University Student Personnel Services, Ottawa, 1972, 69p.
- 7. Biomedical subject headings; a comparative listing of National Library of Medicine (MeSH) and Library of Congress subject headings, by Eugenc V. Muench. Hamden. Conn., Shoe String Press, 1971, 452p.
- 8. Canadian reference sources; a selective guide, edited by Dorothy E. Ryder. Ottawa. Canadian Library Association, 1973, 185p.
- 9. Cataloguing standards; the report of the Canadian Task Group on Cataloguing Standurds. Ottawa, Information Canada, 1972. 91p.
- 10. A conceptual framework for an associate program in nursing, by Marguerite E. Schumacher, Red Deer, Alta., Red Deer College, 1970, 1 vol.
- tt. Corpus administrative index. Toronto, Corpus Publishers Services, 1973. I vol. R
- 12. Educational facilities with new media: the final report of an architectural research study conducted by the staff of the Center for Architectural Research, Rensselaer Polytechnic Institute, Troy. N.Y., School of Architecture. Edited by Alan C. Green et al. Washington, D.C., National Education Association, 1966. 3 vols. in t.
- 13. L'enquête par questionnaire; manuel à l'usage du practicien, par Claude Javeau.

#### Countdown 1972

Countdown 1972, a book of Canadian nursing statistics, has recently been published by the Canadian Nurses Association. Copies are \$5.50 and may be ordered from CNA House, 50 The Driveway, Ottawa, Ont. K2P 1E2. Please include payment with the order.

#### accession list

- 2éd. Bruxelles, Editions de l'Univ. de Bruxelles, 1971, 261p.
- 14. Guide pratique de l'infirmière, par Audrey Latshaw Sutton. Montreal, Editions HRW, 1973. 228p.
- 15. Head start; a tragicomedy with epilogue, by James S. Payne et al. New York, Behavvioral, 1973, 253p.
- 16. History and trends of professional nursing, by Gerald Joseph Griffin and Joanne King Griffin. 7ed. St. Louis, Mosby, 1973, 311p.
- 17. The hotplate cookbook, by Renata von Baeyer. Vancouver, B.C., Vancouver-Burrard Presbyterial United Church Women, 1973. 95p.
- 18. How to prepare a research proposal; suggestions for those seeking funds for behavioral science research, by David R. Kratl. wohl. Syracuse, N.Y., Syracuse Univ., 1965, 50p.
- 19. Introduction an nursing, par Beverly Witter Du Gas. Montreal, Editions HRW, 1973, 470p.
- 20. Job satisfaction as an indicator of quality of employment, by Stanley E. Seashore. Ottawa, 1973, 48p.
- 21. Length of stay tables, all short-term hospitals, 1972. Toronto, Ontario Hospital Services Commission, 1973. I vol.
- 22. Length of stay tables short-term nonteaching hospitals with 300 or more beds, 1972. Toronto, Ontario Hospital Services Commission, 1973. 1 vol.
- 23. Looking into leadership, monographs. Washington, D.C., Leadership Resources Inc., 1972. 3 nos. in 1 vol.
- 24. Mémoire sur le projet de règlements en vertu de la loi sur les services de santé et les services sociaux. Montreal, Association des Administrateurs d'Hôpitaux de la Province de Québec, 1972, 99p,
- 25. Nursing the open-heart surgery patient, by Mary Jo Aspinall. Toronto, McGraw-Hill, 1973. 303p.
- 26. Nonbook materials; the organization of integrated collections, by Jean Riddle Weihs et al. led. Ottawa, Canadian Library Association, 1973, 107p.
- 27. On delegation in medicine and dentistry, by F.H. Weisz, Alphen aan den Rijn, Samson, 1972, 212p.
- 28. A practical manual on reproduction, published under the editorship of Jacques-E. Rioux, assisted by John Collins, by the Canadian Fertility Society. Quebec, University of Laval Press, 1973, 329p.
- 29. Progress in pediatric surgery, v.4 and v.5. Baltimore, Md., University Park Press, 1973
- 30. Radiation therapy in Connecticut, by L. Todd Berman. North Haven, Conn.. Connecticut Health Services Research Series, 1972. 90p.

- 31. Relative stay index report, 1972. Toronto, Ontario Hospital Services Commission, 1972. 1 vol.
- 32. Répertoire des vedettes-matières, par Laval Université, Bibliothèque. Quebec, P.Q., 1972. 2 vols.
- 33. Respiratory technology: a procedure manual, by Doris L. Hunsinger et al. Reston. Va., Reston, 1973, 278p.
- 34. Soins infirmières en médecine et en chirurgie, par Kathleen Newton Shafer et al. Québec. Presses de l'université Laval. 1973. 1014p.
- 35. A study of nursing occupations; registered nurse, licensed vocationally practical nurse, nursing aid, by Katherine L. Goldsmith et al. Rev. Los Angeles, California University, Division of Vocational Education. Allied Health Professions Projects, 1971, 121p.
- 36. A survey of automated activities in the libraries of the U.S. and Canada. Compiled by Frank S. Patrinostro and Debra New. 2ed. Costa Mesa, Calif., LARC Association, 1971. 1 vol.
- 37. La transformation des systèmes d'éducation; un colloque et un séminaire sur le rapport de la Commission internationale sur le Développement de l'Education instituée par l'Unesco, 26 jan., 1973, en collaboration avec le service d'éducation permanente de l'université de Montreal. Montreal, Institut canadien d'Education des Adultes, 1973. 63p. 38. The V.D. story, by Stewart M. Brooks. Totowa, N.J., Littlefield, Adams, 1972. 162p.
- 39. Woman's doctor; a year in the life of an obstetrician-gynecologist, by William J. Sweeney with Barbara Lang Stern. New York, William Morrow, 1973. 318p.

#### PAMPHLETS

- 40. Accident research. Edited by Darla Fishbein Strouse and Janice R. Westaby. Chapel Hill, N.C., North Carolina University School of Public Health, 1968, 2 vols.
- 41. Bibliotherapy; an annotated bibliography, compiled by Corrine W. Riggs. Newark, Del., International Reading Association, 1971. 26p.
- 42. A clinical guide to oral contraception, by Shirley Okrent, Wantagh. N.Y., 1971.
- 43. Development of a quality of working life questionnaire: item discrimination study by M.F. Helzel et al. Ottawa, 1973. 1 vol.
- 44. Fucts from our environment. Atlanta, Ga., Potash Institute of North America, 1972.
- 45. Is the quality of life improving? How can you tell? And who wants to know? by

#### Library Loan Service

As usual, mailing of material on loan for the library will be curtailed over the holiday mailing season. Loans will not be mailed out, therefore, between December 3, 1973 and January 4, 1974.

- Norman M. Bradburn. Ottawa, 1973. 28p.
- 46. Orientation des services infirmières en Europe; rapport d'un groupe de Travail, Berne 16-18 déc., 1970. Copenhague, Organisation Mondiale de la Santé, Bureau régional de l'Europe, 1972. 27p.
- 47. The Pan American Health Organization; what it is...what it does...how it works. Washington, D.C., Pan American Health Organization. Pan American Sanitary Bureau. pam.
- 48. Planning staff training programs, by Hedley G. Dimock. Montreal, Sir George Williams University, 1973. 43p.
- 49. Population policy and national development, by George F. Brown. Ottawa, International Development Research Centre, 1972. 12p.
- 50. Procedure to enable a nurse to perform a medical act. Montreal, Association of Nurses of the Province of Quebec, 1973.
- 51. QWL indicators—prospects and problems, by Richard E. Walton. Ottawa, 1973. 21p.
- 52. Report, 1972. London, King Edward's Hospital Fund for London, 1973, 32p.
- 53. Schéma théorique du programme d'enseignement infirmier de base, par Marguerite E. Schumacher. Montréal, Association des Infirmiers et Infirmières de la Province de Québec, 1972, 27p.
- 54. Sources of statistical data for Ontario, by Dean Tudor, Ottawa, Canadian Library Association, 1972, 33p.
- 55. Sport pour tous; les activités physiques et la prévention des maladies, faits et chiffres, par Ph. Reville. Strasbourg, Conseil de l'Europe, Conseil de la Coopération culturelle, 1970. 46p.
- 56. The state of the art of social auditing, by Raymond A. Bauer. Ottawa, Labour Canada, 1973. 48p.
- 57. Young children in brief separation; a fresh look, by James and Joyce Robertson. London, Tavistock Child Development Research Unit, Tavistock Centre, 1971. p. 264-315. Reprinted from: The Psychoanalytic study of the child, vol. 26, New York, Quadrangle Books, 1971.
- 58. Youth and drugs; report of a WHO Study Group. Geneva, World Health Organization, 1973. 25p. (Its Technical report series no. 516)

#### GOVERNMENT DOCUMENTS

#### Canada

- 59. Dept. of Indian Affairs and Northern Development. *The Canadian Indian; a brief outline*. Ottawa, Information Canada. 1973.
- 60. Dept. of the Secretary of State. *Canadian Bill of Rights*. Ottawa, Information Canada, 1972. I folder.
- 61. Health and Welfare Canada. *Immunization*; a guide for international travellers. Ottawa, Information Canada, 1972. 31p.
- 62. Research and Statistics Directorate. *Poison control program statistics*, 1971. Ottawa, 1973, 170p.
- 63. Labour Canada. Accident investigation

and reporting. Ottawa, Information Canada, 1972. pam. (Canada, Occupational safety manual, part 3)

64. Law Reform Commission. First research program of the Law Reform Commission of Canada. Ottawa, Information Canada, 1972. 21p.

65.—. A study paper prepared by the Project on the General Principles of the Criminal Law. Ottawa, 1973. 1 vol.

66. — Study papers prepared for the Prohibited and Regulated Conduct Project, Ottawa, 1972. 1 vol.

67. Science Council of Canada, Canada, science and international affairs. Ottawa, Information Canada, 1973. 66p. (Its Report no. 20)

68. Standards Council of Canada. Outline metric (SI) standards conversion program. An informative guide to coordinated action. Ottawa, 1973. I vol.

69. Statistics Canada. Canadian job vacancy survey: technical appendix, 1972. Ottawa, Information Canada, 1972. 1 vol.

70. —, Cardiovascular-renal mortality, 1950-1968. Ottawa, Information Canada, 1973. 96p.

71. — Education in the Atlantic provinces, 1970/71. Ottawa, Information Canada, 1972. 223p.

72. — Enrolment in elementary and secondary schools in Canada 1971/72. Ottawa, Information Canada, 1973, 1 vol.

73.—. Non-institutional special care facilities and programs, 1971/72. Published by authority of Statistics Canada and Health and Welfare Canada. Ottawa, Information Canada, 1972, 90p.

74. — Survey of libraries. Part 1: public libraries, 1970. Ottawa, Information Canada, 1973. 53p.

75. Statistique Canada, L'emploi dans l'administration publique fédérale dans les régions métropolitaines, 1972. Ottawa, Information Canada, 1973. 27p.

76. — Rapport annuel sur les maladies à déclaration obligatoire 1972. Ottawa, Information Canada, 1973. 44p.

United States

77. Health Care Facilities Service. Administrative services and facilities for hospitals; a planning guide. Washington, D.C., U.S. Govt. Print, Off., 1972, 103p. (DHEW Publication no. (HSM) 72-4035)

78. Congress. Senate. Special Committee on Aging. A report to the delegates from the conference sections and special concerns sessions, Nov. 28 — Dec. 2, 1971. Washington, D.C., U.S. Govt. Print. Off., 1971. 151p.

#### STUDIES DEPOSITED IN CNA REPOSITORY COLLECTION

79. Analyse des concepts "care" et "cure," en nursing, par Guy-Anne Garceau et Odile Larose. Montreal, 1973. (Thèse (M.Nurs.) — Montréal) R

80. The effects of a nursing intervention on women's retrospective evaluations of their labor experiences; an experimental study, by M.T. Mildred Morris, New Haven, Conn., 1973. (Thesis (M.Sc.N.) — Yale) R



## HUMBER MEMORIAL HOSPITAL

Telephone 249-8111 (Toronto) 200 Church Street, Weston, M9N-1M8, Ont.

Registered Nurses and Registered Nursing Assistants seeking employment in an active treatment hospital in NORTH WEST METROPOLITAN TORONTO, are requested to write to the Director of Nursing concerning employment opportunities.

Orientation and Staff Development Programmes are provided.

Competitive salaries offered to qualified personnel. Registered Nurses are urgently required for temporary employment July, August and September.

#### classified advertisements

#### ALBERTA

DIRECTOR OF NURSING required for 21-bed active treatment hospital. Previous supervisory experience a definite asset. Apply stating qualifications, experience, references and salary expected to: Administrator. Berwyn Municipal Hospital, Berwyn, Alberta.

DIRECTOR OF NURSING required for modern 25-bed Hospital on Highway 12, East Central Alberta. Please apply to: Administrator, CORONATION MUNICIPAL HOSPITAL, CORONATION, ALBERTA, TOC 1C0. Telephone: 578-3691

REGISTERED NURSES required immediately for 72-bed accredited, active treatment hospital. Also 1 R.N. for 50-bed Nursing Home. ARN-AHA contract in force. Refund of fare after one year of service. Apply: Director of Nursing, Providence Hospital, High Prairie. Alberta TOG 1E0.

#### BRITISH COLUMBIA

HEAD NURSE required for Cardio Vascular ward in 400-bed acute care referral hospital with expansion program. Baccalaureate Degree and coronary care nursing experience required. Apply to: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

#### **ADVERTISING** RATES

FOR ALL CLASSIFIED ADVERTISING

\$15.00 for 6 lines or less \$2.50 for each additional line

Rates for display advertisements on request

Closing date for copy and cancellation is 6 weeks prior to 1st day of publication month.

The Canadian Nurses' Association does not review the personnel policies of the hospitals and agencies advertising in the Journal. For authentic information, prospective applicants should apply to the Registered Nurses' Association of the Province in which they are interested in working.

Address correspondence to:

Canadian Nurse



50 THE DRIVEWAY OTTAWA, ONTARIO K2P 1E2

#### BRITISH COLUMBIA

REGISTERED NURSES AND LICENSED PRACTICAL NURSES WANTED FOR FULLY ACCREDITED HOS-PITAL EXPANDING TO 190 BEDS IN JANUARY 1974. GENERAL DUTY POSITIONS IN MEDICAL-SURGICAL GENERAL DOLLY POSITIONS IN MEDICAL-SURGICAL PSYCHIATRIC AND ICU-CCU AREAS. MUST BE ELIGIBLE FOR B.C. REGISTRATION, BASIC SALARY 1973 — \$672.00 (NEW CONTRACT BEING, NEGOTIAT, ED). APPLY: DIRECTOR OF NURSING, ST JOSEPH'S GENERAL HOSPITAL, COMOX, BRITISH COLUMBIA

OPERATING ROOM NURSE wanted for active modern acute hospital. Four Certified Surgeons on attending staff. Experience of training desirable. Must be eligible for B.C. Registration. Nurses residence available. Salary \$687 per month starting. Apply to: Director of Nursing, Mills Memorial Hospital. 2711 Tetrault St., Terrace, British Columbia.

EXPERIENCED NURSES required in 409-bed acute Hospital with School of Nursing. Vacancies in medical, surgical, obstetric, operating room, pediatric and Intensive Care areas. Basic salary \$672.—\$842. B.C. Registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

GENERAL DUTY AND OPERATING ROOM NURSES for modern 450-bed hospital with School of Nursing. RNABC policies in effect. Credit for past experience and postgraduate training. B.C. Registration required. For particulars write to: Acting Director of Nursing Service, Victoria General Hospital, Victoria, British Columbia.

GENERAL DUTY NURSES, for modern 35-bed hospital located in southern B.C.'s Boundary Area with excellent recreation facilities. Salary and personnel policies in accordance with RNABC. Comfortable Nurses's home. Apply: Director of Nursing, Boundary Hospital, Grand Forks, British Columbia.

GENERAL DUTY NURSES for modern 41-bed hospital, located on the Alaska Highway. Salary and personnel policies in accordance with RNABC Accommodation available in residence. Apply: Director of Nursing, Fort Nelson General Hospital, Fort Nelson, British Columbia.

GENERAL DUTY NURSES required immediately for hospital in central B.C. This is a new hospital opened in May or this year. Residence accommodations available. RNABC policies in effect. Apply to: Director of Nurses. St. John Hospital, Vanderhoof, British Columbia.

#### MANITOBA

Required immediately — 3 REGISTERED NURSES and 3 LICENSED PRACTICAL NURSES for a new 60-bed Personal Care Home. Salary in accordance with the recommendations of the MARN Apply: Director of Nursing, Swan River Valley Personal Care Home Inc., SWAN RIVER, Manitoba ROL 1Z0.

#### **NOVA SCOTIA**

REGISTERED NURSES (3) for general duty and (1) with Operating Room experience required for 22-bed hospital in Sheet Harbour, Nova Scotia (situated on the scenic Eastern Shore). Apply to: Administrator, Eastern Shore Memorial Hospital, Sheet Harbour,

#### NOVA SCOTIA

REGISTERED NURSES, PSYCHIATRIC NURSES AND CERTIFIED NURSING ASSISTANTS. General staff positions available in this modern, 270-bed psychiatric hospital, located in the Annapolis Valley. Orientation and Inservice provided. Excellent personnel policies. Salary according to scale. For further information direct inquiries to: The Director of Nursing, Kings County Hospital, Waterville, Nova Specials.

#### ONTARIO

Applications for the position of: NURSING ADMINISTRATIVE SUPERVISOR and HEAD NURSE for the Paediatric Department of a 143-bed General Hospital are now being accepted. Preference will be given to applicants with formal preparation in Nursing Service Administration, but those with administrative experience will be considered. Completely furnished apartments with balcony and swimming pool adjacent to hospital and lake are available, and the location is within easy driving distance of American and Canadian metropolitan centres. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

SUPERVISOR OF PUBLIC HEALTH NURSING: for progressive Health Unit with generalized program. Nursing degree essential, supervision and administration preferred. Excellent personnel policies. Apply. Dr. V. Soudek, Medical Officer of Health, Leeds, Grenville & Lanark District Health Unit, Box 130, Prophylika Optoria. Brockville, Ontario.

REGISTERED NURSES for 34-bed General Hospital. Salary \$646, per month to \$756, plus experience allowance. Excellent personnel policies. Apply to: Director of Nursing Englehart & District Hospital Inc., Englehart, Ontario.

REGISTERED NURSES required for a new 79-bed General Hospital in bilingual community of Northam Ontario, French language an asset, but not compulsory. Salary is \$645. to \$758. monthly with allowance for past experience, 4 weeks vacation after 1 year and 18 sick leave days per year. Unused sick leave days paid at 100% every year. Master rotation in effect. Rooming accommodations available in town. Excellent personnel policies. Apply to: Personnel Director, Notre-Dame Hospital, P.O. Box 850, Hearst, Ont.

REGISTERED NURSES required immediately for 30-bed general hospital. Salary range \$650 — \$760 with allowance for experience. Residence accommodation available. Apply: Mrs. M. Simmonds, R.N. Director of Nursing, Bingham Memorial Hospital, Matheson, Ontario. Phone: (705) 273-2424.

REGISTERED NURSES AND REGISTERED NURSING ASSISTANTS for 45-bed Hospital. Salary ranges include generous experience allowances R.N.'s salary \$445. to \$745. and R.N.A.'s salary \$445. to \$530. Nurses' residence — private rooms with bath — \$40. per month. Apply to: The Director of Nursing, Geraldton District Hospital, Geraldton, Ontario.

REGISTERED NURSES and REGISTERED NURSING ASSISTANTS for 83-bed Home for Mentally Retarded and Physically Handicapped Children. 40 Hour Week. Accommodation available. RN's salary \$600 — 720 and RNA's \$520 — \$620. plus allowance for experience. Apply to: Lakewood Nursing Home, Box 1830, Huntsville, Ontario. POA 1KO.

REGISTERED NURSES for General Duty and I.C.U. — C.C.U. Unit required for 162-bed accredited hospital. Starting salary \$645.00 with regular annual increments. Excellent personnel policies. Temporary residence accommodation available. Apply to: The Director of Nursing, Kirkland and District Hospital, Kirkland Lake, Ontario.

## **1973 INDEX**

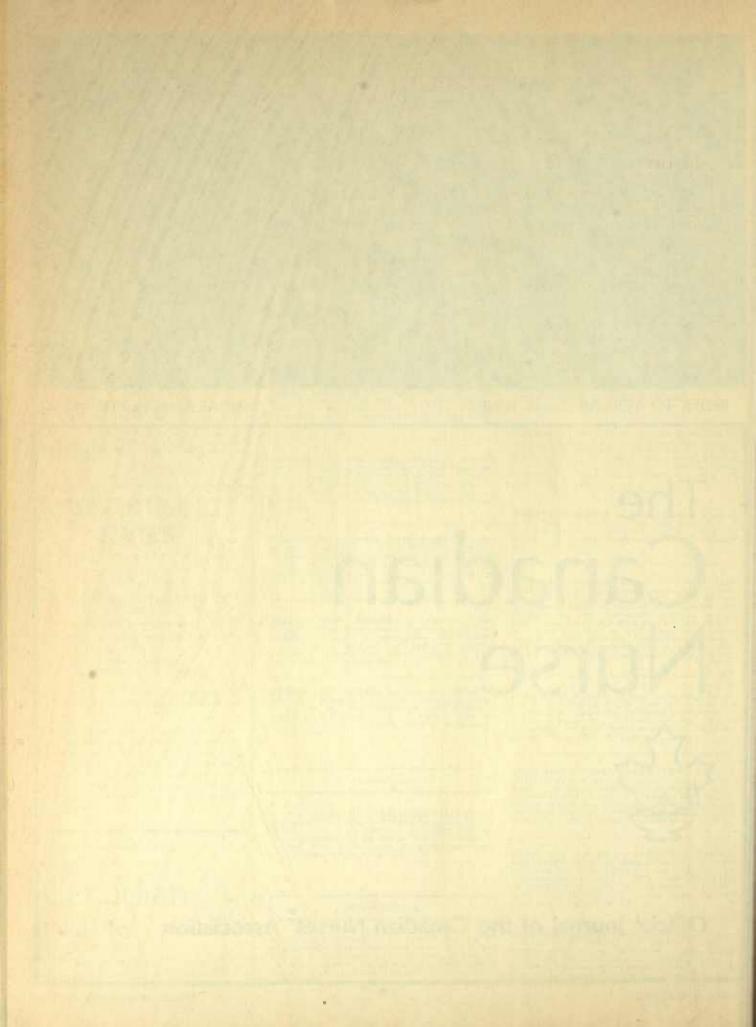
INDEX TO VOLUME SIXTY NINE

JANUARY-DECEMBER 1973

# The Canadian Nurse



Official Journal of the Canadian Nurses' Association



#### ABOUD, Viola

Assistant executive director, St. Joseph's Hospital, Guelph, (port), 43 (Dec)

#### ABRAHAM, P.Y.

Bk. rev., 40 (Jul.)

#### **ACCESSION LIST**

51 (Jan), 56 (Feb), 56 (Mar), 54 (Apr), 51 (May), 48 (Jun), 44 (Jul), 44 (Aug), 59 (Sep), 56 (Oct), 40 (Nov), 51 (Dec)

#### ACCIDENTS

Editorial, (Lindabury), 3 (Jul)

#### ACCREDITATION

CNA directors at work..., 17 (Mar),

#### **ACUPUNCTURE**

Acupuncture, (Armstrong), 26 (Feb)

#### AIKEN, R. Catherine

Study leave as dean of faculty of nursing at University of Western Ontario, 48 (Feb)

#### AIR CANADA

Health care at Toronto International Airport, (Starr), 32 (Feb)

#### ALBERTA, DEPT. OF HEALTH

A. Viola Flanagan nursing consultant in Division of Tuberculosis Control, 42 (Dec)

Pat Dalenger nursing consultant in family planning, 42 (Dec)

#### ALBERTA ASSOCIATION OF REGISTERED NURSES

Alberta nurse honored, (port), 38 (Aug)

Alberta nurses and hospitals accept conciliation board award, 16 (Dec)

Alice R. MacKinnon registrar, (port), 39 (Aug)

Ann Dorothy Shaw public relations officer, (port), 36 (Nov)

Audrey Thompson chosen nurse of the year. (port), 38 (Aug)

Robert R. Donahue public relations officer, (port), 47 (Mar)

Says nurses' jobs available in Alberta, 12 (Mar)

#### ALCOHOLISM

Detoxification: an alternative in transition, (Funston), 27 (Nov)

#### ALLEN, Ann Frances

Hold a fair, stock a cart: for inservice education, 38 (Sep)

#### ALLEN, F. Moyra

Bk. rev., 49 (May)

Senior health scientist award from government of Canada, 16 (Jul)

#### ALLT, Brenda Marion

Director of nursing service, Halifax, Infir-

#### AMERICAN JOURNAL OF NURSING COMPANY

Tape cassettes, 50 (Sep)

mary, 47 (May)

#### **AMERICAN NURSES' ASSOCIATION**

Canadian nurse admitted to nurse researchers' group, 12 (Aug)

U.S. Senator responds to ANA during Watergate hearings. 12 (Nov)

#### ANDERSON, Dan

Employment relations dept. RNAO, 41 (Dec)

#### ANDERSON, M. Leslea

Bk. rev., 53 (Sep)

#### ANDERSON, Marjorie C.

Faculty University of Calgary, School of Nursing, (port), 47 (May)

#### ANGUS, Monica D.

Awarded 1972 Alice E. Wilson Award and elected to UBC Senate, (port), 48 (Feb)

#### AQUINO, Evelyn C.

Assistant professor at University of Windsor, (port), 48 (Feb)

#### ARCAND, Rhea

Staff at Grant MacEwan Community College, (port), 45 (Jan)

#### ARCHIBALD, Barbara

How CNF scholars are selected, (Henderson), 33 (May)

#### ARENS, Roberta

SRNA bursary, 48 (Mar)

#### ARKLIE, Margaret Muir

Bk. rev., 51 (Mar) CNF scholarship, 12 (Sep)

#### ARMSTRONG, Louisa Jane

NBARN scholarship, 42 (Dec)

#### ARMSTRONG, Margaret E.

Acupuncture, 26 (Feb)

#### ASSOCIATION OF NURSES OF PRINCE EDWARD ISLAND

Ella MacLeod apointed to PEI Civil Service Commission, (port), 43 (Jun)

#### ASSOCIATION OF NURSES OF THE PROVINCE OF QUEBEC

Committee working on plan for nursing education in Quebec, 8 (Nov)

Editorial, (Lockeberg), 3 (Sep)

Goals reflected in new Quebec legislation, 7 (Aug)

Nicole Du Mouchel promoted to rank of major in the Canadian Forces Reserve, (port), 36 (Nov)

1,755 nurses discuss legislation at ANPQ meeting via phone relays, 10 (Jun)

Recommendations included in Quebec hospital regulations, 8 (Feb)

Success in defining nursing explained at CNA annual meeting, 5 (Jun)

See also Order of Nurses of the Province of Quebec

#### ASSOCIATION OF REGISTERED NURSES OF NEWFOUNDLAND

Keynote speaker at ARNN meeting has advice for associations, 8 (Nov)

Nfld. hospital nurses reject new collective agreement, 7 (Oct)

Newfoundland nurses accept new government contract offer. 15 (Dec)

Phyllis Barrett executive secretary. (port), 36 (Nov)

#### AUDIO VISUAL AIDS

50 (Jan), 55 (Mar), 50 (May), 45 (Jun), 40 (Sep), 55 (Oct)

AV equipment donated to Winnipeg School of Nursing, 45 (Jun)

VD — name your contacts, 55 (Mar)

VIPS catalogue, 51 (May)

About conception and contraception, 55 (Mar)

Aids for health teaching: a catalog for schools, 50 (Jan)

Alcohol, 55 (Oct)

Au-Vid learning system, 50 (Jan)

Barnet, 55 (Mar)

Being, 55 (Mar)

Better than it was before, 50 (Jan)

Bilingual film catalog from WHO, 50 (Sep)

Bitter wind, 55 (Oct)

Casual ties, casualties, 45 (Jun)

Catalog of Canadian resources on the family, 51 (May)

Child behaviour equals you, 45 (Jun)

Closed circuit TV, 51 (May)

Death and mourning, 55 (Mar)

Drug dependence other than alcoholism, 50 (Sep)

The effects of error modeling on the learning of a complex procedure in nursing, (Parker), (abst), 50 (Feb)

Every thirty seconds, 55 (Mar)

Films available from CHA, 50 (Sep) Generation, 45 (Jun)

Get fit — keep fit, 50 (Sep)

A handbook of Canadian film, 50 (Sep)

Health begins at home, 50 (May)

Hearing conservation, 50 (May)

Help is, 55 (Mar)

Listen while you can, 50 (May)

Mediascience, 55 (Oct)

Methods of family planning, 55 (Mar)

Multimedia catalogue for education, 55 (Mar)

Public health currents, Nov./Dec. 1972, 51 (May)

Publications and films on health and safety, 50 (Jan)

Purposes of family planning, 45 (Jun) Skin welfare — your action, 50 (May) Smoking: it's your choice, 45 (Jun)

Tape cassettes, 50 (Sep)

Tapes on telephone, 51 (May)

The third eye, 51 (May)

This is where we live, 55 (Mar) You got what? 55 (Mar)

#### **AWARDS**

Canadian nurse awarded 3M nursing fellowship, (port), 9 (May)

Helen Roberta Irwin awarded Kathleen Ellis prize, (port), 16 (Jul)

Jane Clouston Hutchings member of Order of Canada, 48 (Apr)

Joyce Nevitt fellow of Royal Society of Health, (port), 47 (Mar)

Monica D. Angus awarded Alice E. Wilson Award and elected to UBC Senate, (port), 48 (Feb)

Ontario Heart Foundation offers fellowship for master's degree, 17 (Feb)

Red Cross bursary available to Ontario nurses, 19 (Mar)

#### AYOTTE, William Alexander

Assistant director of nursing at Prince George Regional Hospital in Prince George, B.C., 49 (Mar)

В

#### BAHRO, Lydia

Mildred 1. Walker Bursary Fund award, 17 (Jul)

#### BAILEY, Donald

Physical fitness of children leaves much to be desired physician tells audience. 11 (Jan)

#### BAIZLEY, Lesley

Whose baby is this? 27 (Mar)

#### BALLANTYNE, Wilma

Member emeritus of RNAO, 16 (Jul)

#### BARR, Laura

Canadians on ICN committees ready reports for 1973 congress, 11 (Mar)

#### BARRETT, Phyllis

Executive secretary ARNN, (port), 36 (Nov)

#### BATRA, Carol

Bk. rev., 52 (Oct)

#### BAUMGART, Alice J.

Canadian nurse awarded 3M nursing fellowship, (port), 9 (May)

Elected to senate of UBC, (port), 48 (Mar)

#### BEARDALL, Peter J.

Laparoscopy, 34 (Apr)

#### BELLEMARE, Raymond

Reception in honor of new Jeanne Mance stamp. (port), 6 (Jun)

#### BENNETT, Margaret D.

Bk. rev., 55 (Sep)

Staff at McMaster University School of Nursing, 46 (Jan)

#### BENOIT, Edith Vivian

Assistant professor at UBC, (port), 46 (Jan)

#### BENTLEY, E. Margaret

President of Canadian Public Health Association. Nova Scotia branch, (port), 48 (Feb)

#### BERGIN, Jane

Nurses, smoking, and schoolchildren, (et al), 19 (Jul)

#### BESWETHERICK, Margaret A.

Bk. rev., 53 (Feb)

#### BEZAIRE, Bernadette, Sister

Elected to SRNA council, 44 (Sep)

#### BIEBER, Otillia

Saskatchewan workshop asks how nurses rate as educators, 14 (Feb)

#### BIETTE, Gayle

Street nurses in blue jeans, (Ruiterman), 34 (Jan)

#### BIGUE, Claire

Reception in honor of new Jeanne Mance stamp, (port), 6 (Jun)

#### BIOLOGY

Work is a basic biologic need Selye tells fitness conference, 10 (Feb)

#### BIRTH CONTROL

CNA research officer heads FP research advisory group, 9 (May)

Needed: a change in attitudes toward elective sterilization. (Fortier), 21 (Jan)

A new method of tubal ligation, (McBride), 32 (Apr.)

Street nurses in blue jeans, (Ruiterman, Biette), 34 (Jan)

#### BLOOD AND BLOOD DISEASES

World-wide hypertension is hidden epidemic — WHO, 20 (Apr)

#### **BLOOR**, Dianne

Bk. rev., 48 (Jan)

#### **BODNAR**, Danin

Staff at Grant MacEwan Community College. (port), 45 (Jan)

#### BONIN, Marie, Sister

CNF scholarship, 12 (Sep)

#### **BOOK REVIEWS**

Adams, J. Crawford, Arthritis and back pain, 53 (Sep)

Alexander, Edythe L., Nursing administration in the hospital health care system, 53 (Feb)

Altschul, Annie T., Patient-nurse interaction, 43 (Jul)

American College of Surgeons, Committee on Trauma, Early care of the injured patient, 51 (Mar) Armstrong, Katharine F., Anatomy & physiology for nurses, (Jackson), 54 (Apr)

Ashworth, Pat, Cardiovascular disorders: patient care, (Rose), 52 (Oct)

Asperheim, Mary K., The pharmacologic basis of patient care, (Eisenhauer), 43 (Jul)

Aspinall. Mary Jo. Nursing the open-heart surgery patient, 50 (Dec)

Auld, Margaret E., The challenge of nursing: a book of readings, (Birum), 55 (Oct)

Bahn, Anita K., Basic medical statistics, 58 (Sep)

Bailey, Rosemary E., Mayes' midwifery: a textbook for midwives, 43 (Aug)

Ballinger, Walter F., Alexander's care of the patient in surgery, (et al), 41 (Jul)

Barber, Janet Miller, Adult and child care: a client approach to nursing, (et al), 48 (Dec)

Barnard, Kathryn E., Teaching the mentally retarded child: a family care approach, (Powell), 54 (Mar)

Barrett, Irene, Saunders tests for selfevaluation of nursing competence, (Gillies), 54 (Oct)

Bergersen, Betty S., Pharmacology in nursing, 43 (Jul)

Birum, Linda Hulthen. The challenge of nursing: a book of readings. (Auld), 55 (Oct)

Bouchard, Rosemary, Nursing care of the cancer patient, (Owens), 50 (Dec)

Bower, Fay Louise, The process of planning nursing care: a theoretical model, 42 (Jul)

Burgess, Ann C., Psychiatric nursing in the hospital and the community, (Lazare), 57 (Sep)

Burnside. Irene Mortenson, ed., Psychosocial nursing care of the aged, 48 (Dec)

Burrell, Lenette Owens, Intensive nursing care, (Burrell), 48 (Dec)

Burrell, Zeb L., Intensive nursing care. (Burrell), 48 (Dec)

Bushnell, Sharon Spaeth, Respiratory intensive care nursing, 53 (Oct)

Byrne, Marjorie L., Key concepts for the study and practice of nursing, (Thompson), 51 (Mar)

Cable, James Verney, Principles of medicine, 51 (Mar)

Campbell, Alastair V., Moral dilemmas in medicine, 41 (Jul)

Canadian Council on Social Development, Day care — report of a national study, 55 (Mar)

Canadian Council on Social Development. Proceedings — Canadian Conference on Day Care, Jun. 20-23, 1971, 55 (Mar)

Canadian Council on Social Development, The one-parent family, 56 (Mar)

Clausen, Joy Princeton, Maternity nursing today, (et al), 53 (Sep)

Conover, Mary H., Understanding electrocardiography: physiological and interpretive concepts, (Zalis), 52 (Mar)

- Cookbook for diabetics and all the family, 48 (May)
- Cooper, Signe Skott, Continuing nursing education, (Hornback), 54 (Oct)
- Dally, Peter, Psychology and psychiatry for nurses, (Farnham), 46 (Jun)
- Davis, Phyllis E., Quick medical terminology, (Smith), 53 (Feb)
- Dawson, Rosemary B., Parents and children in the hospital: the family's role in pediatrics, (Hardgrove), 54 (Mar)
- Dept. of National Health and Welfare, Drugs — handle with care, 56 (Mar)
- Du Gas, Beverly Witter, Introduction to patient care: a comprehensive approach to nursing, 42 (Jul)
- Eisenhauer, Laurel A., The pharmacologic basis of patient care, (Asperheim), 43 (Jul)
- Elliott, Hazel, Venereal diseases: treatment and nursing, (Ryz), 40 (Jul)
- Family planning publications from NHW, 56 (Mar)
- Farnham, Susan, Psychology and psychiatry for nurses, (Dally), 46 (Jun)
- Foley, Archie R., Challenge to community psychiatry, 56 (Sep)
- Fotheringham, John B., The retarded child and his family, (et al), 49 (Jan)
- Gahart, Betty I., Intravenous medications; a handbook for nurses and other allied health personnel, 49 (Dec)
- Gardner, Alvin F., Paramedical pathology: fundamentals of pathology for the allied medical occupations, 48 (Jan)
- Gillies, Dee Ann, Saunders tests for selfevaluation of nursing competence, (Barrett), 54 (Oct)
- Goligher, J.C., ed., The care of your colostomy, (Pollard), 38 (Nov)
- Gottesfeld, Harry, The critical issues of community mental health, 56 (Sep)
- Griffin, Gerald J., Fundamentals of patient-centered nursing, (et al), 49 (Jan)
- Hamessley, Mary Lou, Handbook for camp nurses and other camp health workers, 42 (Aug)
- Hamilton, William P., Decision making in the coronary care unit, (Lavin), 48 (May)
- Hardgrove, Carol B., Parents and children in the hospital: the family's role in pediatrics, (Dawson), 54 (Mar)
- Hoddinott, Bernard A., The retarded child and his family, (et al), 49 (Jan)
- Hogan, Alice E., Fundamentals of patientcentered nursing, (et al), 49 (Jan)
- Hornback, May Shiga, Continuing nursing education, (Cooper), 54 (Oct)
- Hurtado, Arnold V., Home care and extended care in a comprehensive prepayment plan, (et al), 44 (Jul)
- Illingworth, R.S., The development of the infant and young child, 51 (Mar)
- International Council of Nurses, 1973 national reports of ICN member associations, 42 (Jul)
- Jackson, Sheila M., Anatomy & physiology for nurses, (Armstrong), 54 (Apr)
- Jones, R.S., Care of the critically ill child, (Owen-Thomas), 42 (Aug)

- Kastenbaum, Robert, ed., Research planning and action for the elderly, (et al), 49 (May)
- Kent, Donald P., ed., Research planning and action for the elderly, (et al), 49 (May)
- Kilpatrick, S. James, Statistical principles in health care information, 58 (Sep)
- Kolh, Lawrence C., Modern clinical psychiatry, 46 (Jun)
- Korones, Sheldon B., High-risk newborn infants: the basis for intensive nursing care, 54 (Feb)
- Lange, Crystal M., Autotutorial techniques in nursing education, 48 (Jan)
- Lavin, Mary Ann, Decision making in the coronary care unit, (Hamilton), 48 (May)
- Lawrence, Seymour, Pregnancy, birth and the newborn baby, 52 (Mar)
- Lazare, Aaron, Psychiatric nursing in the hospital and the community, (Burgess), 57 (Sep)
- McLaren, Donald S., Nutrition and its disorders, 49 (May)
- McVay, Joan Wilcox, The clinical nurse specialist: interpretations, (Riehl), 38 (Nov)
- Marram, Gwen D., The group approach in nursing practice, 49 (Dec)
- Matheney, Ruth V., Fundamentals of patient-centered nursing, (et al), 49 (Jan)
- Mayers, C.P., Pathology, 40 (Jul)
- Miller, James H., Orthopaedics and accidents, (Miller), 43 (Aug)
- Miller, Margaret, Orthopaedics and accidents, (Miller), 43 (Aug)
- Mitchell, Pamela Holsclaw, Concepts basic to nursing, 52 (Oct)
- Moore, Margaret L., Form and function of written agreements in the clinical education of health professionals, (et al), 54 (Sep)
- Moore, Mary Lou, The newborn and the nurse, 53 (Feb)
- Moreno, Judith Wilson, The practice of mental health nursing: a community approach, (Morgan), 51 (Dec)
- Morgan, Arthur James, The practice of mental health nursing: a community approach, (Moreno), 51 (Dec)
- Mosteller, Sue, Sister, My brother, my sister, 52 (Apr)
- Murphy, T.R., Jamieson's illustrations of regional anatomy, (Walmsley), 41 (Jul)
- Nolan, Breda T., Fundamentals of patientcentered nursing, (et al), 49 (Jan)
- Nursing Development Conference Group, Concept formalization in nursing: process and product, 55 (Sep)
- Nursing studies index, 48 (Jan)
- Owen-Thomas, J.B., Care of the critically ill child, (Jones), 42 (Aug)
- Owens, Norma F., Nursing care of the cancer patient, (Bouchard), 50 (Dec)
- Pickering, Edward A., Report of the special study regarding the medical profession in Ontario, 52 (Oct)
- Pollard, Muriel, ed., The care of your colostomy, (Goligher), 38 (Nov)
- Powell, Marcene L., Teaching the mental-

- ly retarded child: a family care approach, (Barnard), 54 (Mar)
- Prescott, Frederick, The control of pain, 53 (Sep)
- Rhodes, William C., Behavioral threat & community response, 57 (Sep)
- Riehl, Joan P., The clinical nurse specialist: interpretations, (McVay), 38 (Nov)
- Robinson, Lisa, Psychiatric nursing as a human experience, 46 (Jun)
- Roper, Nancy, Man's anatomy, physiology, health and environment, 52 (Sep)
- Rose, Harry, Cardiovascular disorders: patient care, (Ashworth), 52 (Oct)
- Rowe, Joyce W., Anatomy and physiology applied for orthopaedic nurses, (Wheble), 52 (Apr)
- Ryan, Thomas J., Poverty and the child: a Canadian study, 54 (Sep)
- Ryz, Kurt, Venereal diseases; treatment and nursing, (Elliott), 40 (Jul)
- Sanderson, Richard G., The cardiac patient: a comprehensive approach, 54 (Mar)
- Satir, Virginia, Peoplemaking, 54 (Apr)
- Sherwood, Sylvia, ed., Research planning and action for the elderly, (et al), 49 (May)
- Shneidman, Edwin S., ed., Death and the college student, 53 (Apr)
- Skelton, Mora, The retarded child and his family, (et al), 49 (Jan)
- Smith, Genevieve Love, Quick medical terminology, (Davis), 53 (Feb)
- Spencer, James H., The hospital emergency department, 42 (Aug)
- Spencer, Roberta T., Patient care in endocrine problems (Saunders monographs in clinical nursing), 56 (Sep)
- Squire, Jessie E., Basic pharmacology for nurses, (Welch), 52 (Oct)
- Stahl, William M., Supportive care of the surgical patient, 52 (Sep)
- Stimson, David H., Operations research in hospitals: diagnosis and prognosis. (Stimson), 49 (May)
- Stimson, Ruth H., Operations research in hospitals: diagnosis and prognosis, (Stimson), 49 (May)
- Stryker, Ruth Perin, Rehabilitative aspects of acute and chronic nursing care, 49 (Jan)
- Thompson, Lida F., Key concepts for the study and practice of nursing, (Byrne), 51 (Mar)
- Treece, Eleanor Walters, Elements of research in nursing, (Treece), 50 (Dec)
- Treece, James William, Elements of research in nursing, (Treece), 50 (Dec)
- Vinsant, Marielle Ortiz, A commonsense approach to coronary care: a program, (et al), 40 (Jul)
- von Baeyer, Renata, The hotplate cookbook, 52 (Sep)
- Walmsley, Robert, Jamieson's illustrations of regional anatomy, (Murphy), 41 (Jul)
- Watson, Luke S., Child behavior modification: a manual for teachers, nurses, and parents, 38 (Nov)
- Weisman, Avery D., On dying and denying: a psychiatric study of termina-

lity, 52 (Apr)

Welch, Jean M., Basic pharmacology for nurses, (Squire), 52 (Oct)

Wheble, Victor H., Anatomy and physiology applied for orthopaedic nurses, (Rowe), 52 (Apr)

Williams, Sue Rodwell, Review of nutrition and diet therapy, 53 (Oct)

Wood, Vivian, Casebook in nursing education, 47 (Jun)

World Health Organization, Health hazards of the numan environment, 53 (Apr)

Wu, Ruth, Behavior and illness, 53 (Apr) York-Toronto Tuberculosis & Respiratory disease Association, Willy and the wheeze, 55 (Mar)

Zalis, Edwin G., Understanding electrocardiography: physiological and interpretive concepts, (Conover), 52 (Mar)

#### BOOKS

48 (Jan), 53 (Feb), 51 (Mar), 52 (Apr), 48 (May), 46 (Jun), 40 (Jul), 42 (Aug), 52 (Sep), 52 (Oct), 38 (Nov), 48 (Dec)

#### **BOURGEOIS**, Antoinette

Awarded NBARN scholarship, 44 (Jun)

#### **BOURQUE**, Lorraine

Testing specialist with CNA Testing Service, (port), 45 (Jan)

#### BRAYTON, Margaret A.

Secretary of Commonwealth Nurses' Federation, 48 (Apr)

#### BRAZEL, Jo

National chairman of CUNSA, 47 (May)

#### **BRIDGES**, Daisy Caroline

Editorial, (Lindabury), 3 (Feb) Obit, 47 (Feb)

#### **BRISTOW**, Louise Leffert

Faculty Dalhousie University school of nursing, (port), 42 (Dec)

#### **BROADBENT**, Lucinda

Assistant director of nursing education, Calgary General Hospital school of nursing, 43 (Dec)

#### BROWN, Ann

Staff at Queen's University school of nursing, 41 (Dec)

#### BROWN, Gillian L.

Faculty U. of Alberta school of nursing, 43 (Dec)

#### BRUIN, Evelyn de

Health care at Toronto International Airport, (port), (Starr), 32 (Feb)

#### BUDGETS

Financial statement CNA, 23 (Mar) Financial statement CNATS, 26 (Mar)

#### **BUZZELL**, E. Mary

Changing nursing practice through educa-

tion. (et al), 28 (Apr)

Staff at McMaster University School of nursing, 47 (Jan)

C

#### CARE/MEDICO

Canadian nurses with CARE help injured in Nicaragua, 14 (Feb)

Christine Emrich joined, (port), 49 (Apr) Eileen Greenwood serving in Surakarta, (port), 26 (Oct)

Winifred McLean Sutherland and William Sutherland to serve, (port), 47 (May)

#### CAHOON, Margaret C.

Bk, rev., 58 (Sep)

#### CALLIN, Mona

Bk. rev., 54 (Mar)

#### CAMERON, Cynthia

Director of Vanier School of Nursing, Ottawa, 49 (Apr)

#### CANADIAN ASSOCIATION OF NEUROLOGICAL AND NEUROSURGICAL NURSES

Neuro nurses sponsor contest for student nurses in Canada, 14 (Jan)

#### CANADIAN ASSOCIATION OF UNIVERSITY SCHOOLS OF NURSING

Dr. Helen Naum honorary membership in Atlantic region, 17 (Jul)

E.A. Electa MacLennan life membership in Atlantic region, 17 (Jul)

#### CANADIAN COUNCIL OF CARDIOVASCULAR NURSES

Founding meeting, 18 (May)

#### CANADIAN COUNCIL ON HOSPITAL ACCREDITATION

CNA directors at work . . . 11 (Jun)

Changes fee formula for hospital survey visits, 12 (Oct)

Ferne Trout nurse consultant, (port), 26 (Oct)

#### CANADIAN FEDERATION OF UNIVERSITY WOMEN

Monica D. Angus received Alice E. Wilson award and was elected to UBC Senate. (port), 48 (Feb)

#### CANADIAN HOSPITAL ASSOCIATION

CNA/CMA/CHA committee favors control of drug advertising, 9 (May)

CNA, CMA, CHA joint committee presents brief to health minister, 9 (Apr)

#### CANADIAN INTERNATIONAL DEVELOPMENT AGENCY

Nancy Garrett on assignment, (port), 43 (Jun)

#### **CANADIAN LABOUR CONGRESS**

CHADFOC will help finance community

health centers, 15 (Sep)

#### CANADIAN MEDICAL ASSOCIATION

CNA/CMA/CHA committee favors control of drug advertising, 9 (May)
CNA, CMA, CHA joint committee presents brief to health minister, 9 (Apr)
Bette M. Stephenson president, 44 (Sep)
The expanded role of the nurse; a joint

"Mediscope" launched, 10 (Jul)

CANADIAN MOTHERCRAFT SOCIETY.

OTTAWA BRANCH

statement of CNA/CMA, 23 (May)

Frances Sikora director, 24 (Oct)

#### THE CANADIAN NURSE

CNA directors at work ..., 18 (Mar)
The Canadian Nurse one of six nursing
journals indexed, 11 (Jan)

#### CANADIAN NURSES' ASSOCIATION

CNA/CMA/CHA committee favors control of drug advertising, 9 (May)

CNA, CMA, CHA joint committee presents brief to health minister, 9 (Apr)

CNA and provincial associations support federally employed nurses who protest salaries below peers, 7 (Dec)

CNA directors at work...policy statements, 18 (Mar)

Anne Hanna writer-editor, 44 (Sep)

Annual meeting dates, 11 (Mar)

Countdown 1972, 15 (Sep)

Demonstration nursing school celebrates 25th anniversary, 7 (Aug)

English visitor meets clinical specialists at CNA House, (port), 48 (Mar)

Executive director advises school of nursing in Uruguay, 7 (Oct)

The expanded role of the nurse: a joint

statement of CNA/CMA, 23 (May)
Financial statement, 23 (Mar)

Gets ready for the day when Canada goes metric, 10 (Jul)

Honors Jean Leask on her retirement, (port), 46 (Mar)

In favor of ICN Committee on Library Resources for Nursing, 11 (Mar)

Membership increases, 8 (Sep)

Membership reverses decision on eligibility for CNATS board, 5 (Jun)

Message from President, (Schumacher), (guest edit), 3 (Mar)

1972-74 biennium priorities, 12 (Mar)

Pay for nurse in expanded role should be salary, not fee: CNA, 11 (Mar)

Policy statement on smoking, 15 (Jun)
Policy statements on the primary care

nurse, 13 (Jun)
Preparing nurses for community is topic

of fall conference, 10 (Jun)

Pres.-elect tells RNAO society needs coping resources, 10 (Jul)

Research officer heads FP research advisory group, 9 (May)

Statement on specialization in nursing,

Supports RNAO statement on nurse-midwifery, 7 (Dec)

## CANADIAN NURSES' ASSOCIATION. ANNUAL MEETING 1973

CNA directors at work . . . 12 (Jun)

## CANADIAN NURSES' ASSOCIATION. BOARD OF DIRECTORS

CNA directors at work...17 (Mar), 11 (Jun)

A capsule account of some issues being examined, 17 (Mar)

Change eligibility for CNATS Board and committees, 11 (Mar)

Cigarettes butted, ashtrays gone and CNA board meeting ends early, 8 (Dec)

Research committee appointed, priorities ranked by directors, 7 (Dec)

Special committee on research continued by CNA directors, 5 (Jun)

#### CANADIAN NURSES' ASSOCIATION. CONVENTION 1974

Fees, 7 (Dec)

1t's Winnipeg in '74, 8 (Aug), 12 (Sep), 16 (Oct)

## CANADIAN NURSES' ASSOCIATION. EXECUTIVE COMMITTEE

Approves responses to school health recommendations, 7 (Feb)

## CANADIAN NURSES' ASSOCIATION. TESTING SERVICE

CNA directors at work . . . 12 (Jun)

CNA directors change eligibility for CNATS Board and committees, 11 (Mar)

Financial statement, 26 (Mar)

Lorraine Bourque, testing specialist, (port), 45 (Jan)

# CANADIAN NURSES' ASSOCIATION. TESTING SERVICE. BOARD OF DIRECTORS

CNA membership reverses decision on eligibility for CNATS board, 5 (Jun)

#### **CANADIAN NURSES' FOUNDATION**

Directors elect officers, study administration costs, 8 (Dec)

How CNF scholars are selected, (Henderson, Archibald), 33 (May)

Members elect directors and delete committees, 8 (Aug)

\$31,500 in CNF scholarships awarded to 10 Canadian nurses, 12 (Sep)

## CANADIAN PUBLIC HEALTH ASSOCIATION

Delegates adopt policy opposing fee-forservice, 7 (Jul)

E. Margaret Bentley president of Nova Scotia branch, (port), 48 (Feb)

New tropical medicine group invites nurses' membership, 18 (Mar)

#### CANADIAN RED CROSS SOCIETY

Beverley M. McCann received bursary from Ontario division of Volunteer Nursing Service Committee, 36 (Nov)

Bursary available to Ontario nurses, 19 (Mar) Eleanor Mitchell director of volunteer nursing services, Ontario Division, 36 (Nov)

Elizabeth Lorraine Holder awarded Volunteer Nursing Services Bursary, 47 (Mar)

#### CANADIAN TEACHERS' FEDERATION

Teachers' brief to government urges revision in copyright act, 11 (Jul)

## CANADIAN UNIVERSITY NURSING STUDENTS ASSOCIATION

Jo Brazel chairman, 47 (May)

#### CANDAU, M.G.

Retired as director-general of WHO, 26 (Oct)

## CANNINGS, Mary Wood

Faculty U. of Alberta school of nursing, 43 (Dec)

## CAPLIN, Alice E.

Bk. rev., 56 (Sep)

Correction, 8 (Oct)

Speaker at SRNA meeting focuses on women's work problems, 7 (Sep)

#### CARIGNAN, Therese, Sister

Executive director MARN, (port), 47 (Feb)

## CARNEGIE, M. Elizabeth

Acting editor of Nursing Research, 26 (Oct)

## CARROLL, Marjorie

Bk. rev., 57 (Sep)

#### CASTONGUAY, Thérèse

Staff at Grant MacEwan Community College, (port), 45 (Jan)

#### CATHOLIC CHILDREN'S AID SOCIETY

Three Toronto institutions unite to help prevent child abuse, 18 (Jan)

#### CEREBRAL PALSY

Talking exerciser for children, 22 (Apr)

#### CHARTERS, Margaret R.

President of Council of College of Nurses of Ontario, 26 (Oct)

## CHARTING

Problem-oriented charting — a nursing viewpoint, (Howard, Jessop), 34 (Aug)

#### CHECKELY, Kenneth Lloyd

The influence of a human relations laboratory on the effectiveness of third-year psychiatric nurses, (abst), 50 (Mar)

## CHESTNUT, Sally

Staff at Queen's University school of nursing, 41 (Dec)

#### CHILDREN AND CHILD HEALTH

Child safety week — for everyone, 42 (Jun)

Independence for phocomelic children, (Côté), 19 (Dec)

Physical fitness of children leaves much to be desired physician tells audience, 11, (Jan)

Three Toronto institutions unite to help prevent child abuse, 18 (Jan)

## CHILDREN'S AID SOCIETY OF METROPOLITAN TORONTO

Three Toronto institutions unite to help prevent child abuse, 18 (Jan)

## CHISHOLM, Catherine, Sister

Associate director of nursing service at Halifax Infirmary, 16 (Jul)

#### **CHRONIC ILLNESS**

Myasthenia gravis, (Stackhouse), 28 (Dec) Ontario RNs attend workshop to improve long-term care, 12 (Jan)

#### CLEGG, David J.

Trace elements in food. (Sandi), 38 (Feb)

## CLEVELY, Dorothy V.

Bk. rev., 54 (Mar)

## **COLLECTIVE BARGAINING**

RNABC seeks bargaining rights for RNs in civil service, 10 (Apr)

RNAO school teaches nurses collective bargaining techniques, 7 (Sep)

RNAO sponsors summer school on collective bargaining 18 (Jan)

RNAO supports central union to replace bargaining units, 8 (Jul)

SRNA ends all involvement in collective bargaining after Supreme Court ruling, 12 (Dec)

Alberta nurses and hospitals accept conciliation board award, 16 (Dec)

Dental plan for nurses included in Manitoba hospital agreement, 15 (May)

First nurses' strike in Alberta ends with 24.7 percent pay increase, 8 (Aug)

Nfld. hospital nurses reject new collective agreement, 7 (Oct)

Newfoundland nurses accept new government contract offer, 15 (Dec)

Nipawin Nurses' Association case argued before Supreme Court, 9 (Aug)

Nova Scotia nurses make gains in 1973 collective agreements, 8 (Nov)

Nurses employed by N.S. Govt. accept new contract offer, 8 (Oct)

Nurses in B.C. civil service receive salary increases, 8 (Aug)

Ont. Nurses' Association formed for province-wide bargaining, 15 (Dec)

Wage settlement in Alberta averts nurses' strike, 12 (Jul)

## COLLEGE OF NURSES OF ONTARIO

First RNAs elected to Council of Ontario College of Nurses, 8 (Aug) Officers elected to Council, 26 (Oct)

#### COLLINSON, Ann

SRNA bursary, 48 (Mar)

## COMMONWEALTH NURSES' FEDERATION

Margaret A. Brayton secretary, 48 (Apr)

#### COMMUNICATION

RNAO told confusion of goals prevents nursing communication, 10 (Jul)

Handicapped children learn written communication, (Maser), 29 (Aug)

A survey to determine the perceptions of a selected group of head nurses and supervisors concerning the channels of communication existing within a hospital, (Hoeffler), (abst), 50 (Apr)

## COMMUNITY HEALTH ASSOCIATIONS DEVELOPMENT FOUNDATION OF CANADA

Will help finance community health centers, 15 (Sep)

#### **COMMUNITY HEALTH SERVICES**

B.C. nurses discuss report on community health centers, 10 (Feb)

CHADFOC will help finance community health centers 15 (Sep)

CNA directors at work . . . , 17 (Mar)

Changing nursing practice through education, (Kergin et al), 28 (Apr)

Community health center opens in highrise apartment complex, 16 (Oct)

85 health and welfare centers closed in Quebec since fall, 1970, 15 (Aug)

Health and community information services, (Kibzey), 39 (Mar)

Nurses will be most affected by community health centers professor tells SRNA meeting, 12 (Aug)

Preparing nurses for community is topic of fall conference, 10 (Jun)

Street nurses in blue jeans, (Ruiterman, Biette), 34 (Jan)

Travels with a nurse in rural Nova Scotia, 20 (May)

## CONFERENCE ON THE CLINICAL NURSE SPECIALIST

Spotlight on the clinical nurse specialist, (Dworkin), 40 (Sep)

#### CONFERENCES AND INSTITUTES

CNA executive approves responses to school health recommendations, 7 (Feb) SRNA, SMA, SHA conference supports joint health planning, 17 (Jun)

Basic health care changes needed nurse tells physicians' meeting, 7 (Nov)

Fitness and health conference aims at fitness for all Canadians, 8 (Feb)

Founding meeting of Canadian Council of Cardiovascular Nurses, 18 (May)

Latin American nurses consider middle level nursing education, 14 (Jan)

Neurology, neurosurgery course proposed for working nurses, 12 (Oct)

Neurosurgical nurses of world federate, plan 1973 meeting, 14 (Mar)

Ont. nursing education, service well

represented at conferences, 18 (May)

Ontario RNs attend workshop to improve long-term care, 12 (Jan)

Preparing nurses for community is topic of fall conference, 10 (Jun)

Saskatchewan workshop asks how nurses rate as educators, 14 (Feb)

Spotlight on the clinical nurse specialist, (Dworkin), 40 (Sep)

Start from where you are directors of nursing told, 12 (Jul)

Work is a basic biologic need Selye tells fitness conference, 10 (Feb)

Workshop on nurse practitioner shows cooperation in N.B., 15 (Aug)

World-wide gonorrhea problem brings researchers together, 15 (Dec)

#### CONSULTANTS

A conceptual model for the provincial nursing consultant in Alberta, (Harrison), (abst), 50 (Apr)

## **CONSUMER SATISFACTION**

Textile care and labeling, 40 (Aug)

#### **CONTAGIOUS DISEASES**

A glimpse of nursing in Cuba, (Mussallem), 23 (Sep)

#### COPYRIGHT

Teachers' brief to government urges revision in copyright act, 11 (Jul)
Xerox solution, 48 (Oct)

#### CORBETT, Dawn

Student nurses share in clinical learning, 21 (Nov)

## CORNELIUS, Dorothy

President of ICN, (port), 16 (Jul)

## **CORONARY CARE**

Coronary patients and their families receive incomplete care, (Royle), 21 Feb)

#### COTE, Denise Mauger

Independence for phocomelic children, 19 (Dec)

#### COUTTS, Roberta

English visitor meets clinical specialists at CNA House, (port), 48 (Mar)

#### CRAIG, Phyllis M.

CNF scholarship, 12 (Sep)

#### CRANE, Eileen Creasey

Faculty U. of Alberta school of nursing, 43 (Dec)

## CRAWFORD, Myrtle E.

Bk. rev., 55 (Oct)

#### CREEGGAN, Sheila

Bk. rev., 50 (Dec)

#### CREELMAN, Lyle

Canadians on ICN committees ready reports for 1973 congress, 11 (Mar)

#### **CUMMINGS**, Carmen

Bk. rev., 53 (Feb)

#### CUNNINGS, Bente

Retired as executive director MARN, 47 (Feb)

#### **CURRICULA**

Students on a curriculum revision committee, (Weinstein), 38 (Mar)

#### DALENGER, Pat

Nursing consultant in family planning with Alberta Dept. of Health, 42 (Dec)

L

#### DALHOUSIE UNIVERSITY

School of nursing faculty, 42 (Dec)

University schools of nursing in Canada, 23 (Jan)

## D'AMOUR, Louise

Director of infant nutrition and family planning services Wyeth Ltd., (port), 48 (Apr)

## DANCAUSE, Ola

Retired, 26 (Oct)

## DARCOVICH, Olga

Bk. rev., 38 (Nov)

Spotlight on the clinical nurse specialist, (Dworkin), 42 (Sep)

#### DARICHUK, Marie

SRNA bursary, 47 (Mar)

#### DARRAH, Florence, Sister

Life membership is NBARN, 16 (Jul)

## DATES

44 (Jan), 45 (Feb), 44 (Mar), 44 (Apr), 44 (May), 41 (Jun), 15 (Jul), 41 (Aug), 43 (Sep), 46 (Oct), 15 (Nov), 47 (Dec)

#### DAVID, Nicole

Appointed to council of social affairs for province of Quebec, 17 (Jul)

#### DAVIDSON, Doris

Bk. rev., 54 (Feb)

#### DAVIES, Betty

Staff at Grant MacEwan Community College, (port), 45 (Jan)

## DAVIS, J.E.

Changing nursing practice through education, (et al), 28 (Apr)

## DeBLOCK, Audry

Bk. rev., 48 (Dec)

## DELANEY, Sheila

Staff at McMaster University School of Nursing, 47 (Jan)

## DeMARSH, Kathleen G.

Red Cross outpost nursing in New Bruns-

wick, 24 (Jun)

Vice-president nursing, Health Sciences Centre, Winnipeg, (port), 43 (Jun)

#### DEMERS, Linda E.

Mildred 1. Walker Bursary Fund award, 17 (Jul)

## **DENIS**, Mary Belle

SRNA bursary, 48 (Mar)

## DEPT. OF NATIONAL HEALTH AND WELFARE

See Health and Welfare Canada

#### DEPT. OF VETERANS AFFAIRS

Grace Johnson retired as consultant in nursing services, 39 (Aug)

## DERHAM, Pat

Bk. rev., 41 (Jul)

#### DIABETES

A diabetic teaching tool, (Skelton), 35 (Dec)

An experimental study to evaluate the effectiveness of a diabetic teaching tool, (Skelton), (abst), 48 (Sep)

Gestational diabetes — when teaching is important (Laugharne, Duncan), 34 (Mar)

#### DIER, Kay A.

Faculty U. of Alberta school of nursing, 43 (Dec)

#### DIETEL, Mervyn

Intravenous hyperalimentation, 38 (Jan)

## DIRKSEN, Wendy S.

Surgical separation of conjoined twins. (Meilicke), 26 (May)

#### DISASTERS AND EMERGENCIES

Canadian nurses with CARE help injured in Nicaragua, 14 (Feb)

Help in a hurry: the crisis clinic, (Mary Mona), 35 (Oct)

Judy Hill, DNHW, died in wreckage of a chartered aircraft, 47 (Feb)

Pegboard as space saver, (Wendril), 43 (Feb)

#### DOIRON, Cheryl

Bk. rev., 48 (Dec)

#### DOLPHIN, Maude

Director of nursing at Maple Ridge Hospital, Maple Ridge, B.C., 36 (Nov)

## DONAHUE, Robert R.

Employment relations department AARN. 36 (Nov)

Public relations officer AARN, (port), 47 (Mar)

#### DONATO, Mary

Faculty Laurentian University school of nursing, 43 (Dec)

#### DRUGS

CNA directors at work..., 18 (Mar), 11 (Jun)

CNA/CMA/CHA committee favors control of drug advertising, 9 (May)

NBARN report to guide nurses who encounter drug problems, 9 (Oct)

Independence for phocomelic children, (Côté), 19 (Dec)

Members at NBARN annual meeting support various recommendations, 8 (Sep)

Travelers warned, 40 (Dec)

#### DU GAS, Beverly Witter

Chief of health manpower planning division, health programs branch, Health and Welfare Canada, (port), 44 (Jun)

#### DU MOUCHEL, Nicole

Elected to 11-member board of directors, (port), 16 (Jul)

Major in Canadian Forces Reserve, (port), 36 (Nov)

### **DUNCAN**, Felicity

Gestational diabetes — when teaching is important, (Laugharne), 34 (Mar)

## DWORKIN, Carol

It's a skater's show on the Rideau, 32 (Dec) Spotlight on the clinical nurse specialist 40 (Sep)

E

#### **ECONOMIC COUNCIL OF CANADA**

Guess who's coming to lunch? 7 (Nov)

#### **EDEMA**

Idiopathic edema, (McKendry), 41 (May)

#### **EDUCATION**

ANPQ committee working on plan for nursing education in Quebec, 8 (Nov)

CNA directors at work..., 17 (Mar), 11 (Jun)

Committee on education of nurses named to advise NBARN council, 12 (Aug)

Freedom: an outmoded tradition, (Gilchrist), 25 (Apr)

How to make microbiology interesting for students, (Murray), 37 (Jul)

Latin American nurses consider middle level nursing education, 14 (Jan)

The nurse in a student physician's "practice," (Valberg), 17 (Nov)

Problems of teachers, students discussed at RNAO meeting, 8 (Jul)

Student nurses share in clinical learning, (Corbett), 21 (Nov)

## EDUCATION, BACCALAUREATE

Changing nursing practice through education, (Kergin et al), 28 (Apr)

University schools of nursing in Canada, 23 (Jan)

#### EDUCATION, CONTINUING

RNAO school teaches nurses collective bargaining techniques, 7 (Sep)

A study to develop instruments to evaluate the effectiveness of a post-diploma program in nursing, (Rivett), (abst), 52 (Feb)

#### EDUCATION, DIPLOMA

New entrance procedure adopted for N.B. diploma schools, 10 (May)

Ont. transfers diploma programs from hospitals to colleges, 14 (Mar)

## **EDUCATION, GRADUATE**

Master of health sciences program will prepare nurses at McMaster, 10 (Apr) Ontario Heart Foundation offers fellow-

ship for master's degree, 17 (Feb)

A study to develop instruments to evaluate the effectiveness of a post-diploma program in nursing, (Rivett), (abst), 50 (Apr)

#### **EDUCATION, HIGHER**

RNANS wants a commission to finance postsecondary education, 18 (Jan)

## ELLIOTT, Ruth

Bk. rev., 51 (Mar)

## ELLIS, Patricia

Bk. rev., 53 (Feb)

#### EMBURY, Sheila B.

Bk. rev., 52 (Oct)

Faculty University of Calgary, School of Nursing, (port), 47 (May)

## EMRICH, Christine

Joined MEDICO, (port), 49 (Apr)

#### **ENDOCRINOLOGY**

Hypoglycemia, (Wolfe, Powers), 38 (Oct)

#### **EPIDEMIOLOGY**

The pandemic influenza of 1918, (Morton), 25 (Dec)

## ETCHES, Merryl

Bk. rev., 46 (Jun)

#### **ETHICS**

ICN code for nurses: ethical concepts applied to nursing, 9 (Aug)

U.S. Senator responds to ANA during Watergate hearings, 12 (Nov)

Code for nurses among topics discussed by ICN committee, 16 (Dec)

Genetic manipulation: now is the time to consider controls, (Siminovitch), 30 (Nov)

Members at NBARN annual meeting support various recommendations, 8 (Sep)

## **EVALUATION**

A study to develop instruments to evaluate the effectiveness of a post-diploma program in nursing, (Rivett), (abst), 52 (Feb)

#### **EYES**

Argon laser photocoagulation for retinal vascular disease, (Rosen), 36 (May)

F

#### **FALCONER**, Paulette

Staff at Grant MacEwan Community College, (port), 45 (Jan)

#### **FAMILY PLANNING**

SRNA welcomes provincial plan to set up family planning program, 9 (Sep)

#### FEEDING

Drink up a tune, (Holland), 39 (Sep)

#### FEES

CCHA changes fee formula for hospital survey visits, 12 (Oct)

CPHA delegates adopt policy opposing fee-for-service, 7 (Jul) 1974 convention fees, 7 (Dec)

#### FEET

Foot mirrors diseases, 48 (Oct)

#### FIELD, Helen L.

Acting director of St. Clair Regional School of Nursing, Sarnia, Ont., (port), 49 (Mar)

#### FINDLAY, Elizabeth

Lenna Richardson honored at retirement, (port), 41 (Dec)

#### FIRST AID

B.C. senior citizens receive instruction in home nursing, 7 (Nov)
Editorial, (Lindabury), 3 (Jul)
First aid for drivers, (Pacy), 23 (Jul)

## FITZGERALD, Doris

Bk. rev., 42 (Aug)

#### FLAHERTY, M. Josephine

Dean of faculty of nursing at University of Western Ontario, (port), 48 (Feb)

## FLANAGAN, A. Viola

Nursing consultant for Alberta, Dept. of Health, Division of Tuberculosis Control, 42 (Dec)

#### FOOTE, Ida M.

Health care at Toronto International airport, (port), (Starr), 32 (Feb)

#### FORD, Ann

Assistant director University Hospital, London, Ont., (port), 49 (Apr)

## FORREST, Darlene Pollock

Faculty U. of Alberta school of nursing, 43 (Dec)

## FORTIER, Lise

Needed: a change in attitudes toward elective sterilization, 21 (Jan)

#### FOURNIER, Yolande

Serving sister of the Order of St. John, (port), 47 (Feb)

#### FOX, Jo-Ann Tippett

Awarded a Medical Research Council studentship, 26 (Oct)
Bk. rev., 40 (Jul)

#### FOY, Esther

Reception in honor of new Jeanne Mance stamp, (port), 6 (Jun)

## FRANCIS, Margaret Rose

Faculty Dalhousie University school of nursing, (port), 42 (Dec)

#### FREEMAN, Lorene Bard

Bk. rev., 40 (Jul)

#### FRENCH, Frances

Honored by Middlesex-London District Health Unit, (port), 45 (Sep)

#### FRENCH, Susan E.

Bk. rev., 52 (Apr)

### FRERE, Virginia

Campus head at Mohawk College dept. of nursing, 42 (Dec)

#### FRY, Jean E.

Bk. rev., 53 (Oct)

#### FRYE, Christine

Viral hepatitis—a risk to nurses, (port), 33 (Jul)

#### FUNKE, Jeanette Thelma

Faculty U. of Alberta school of nursing, 43 (Dec)

#### FUNSTON, Frederick D.

Detoxification: an alternative in transition, 27 (Nov)

G

#### GARDE, Dianne E.

Bk. rev., 38 (Nov)

#### GARDENER, Marjorie, G.

English visitor meets clinical specialists at CNA House, (port), 48 (Mar)

#### GARDNER, Janie

Weekend program for tubal ligation, 37 (Apr)

## GARRETT, Nancy

CNA research officer heads FP research advisory group, 9 (May)
Bk. rev., 58 (Sep)
On assignment with CIDA, (port), 43

(Jun)

Smoking now and then, 22 (Nov)

#### GAUTHIER, Cecile, Sister

MARN Board of Directors, 39 (Aug)

Counsellor to Mother General of Grey Nuns of Montreal, (port), 43 (Dec)

#### GAW, Rachel

Health care at Toronto International airport, (port), (Starr), 32 (Feb)

#### GENETICS

Genetic manipulation: now is the time to consider controls, (Siminovitch), 30 (Nov)

Inside dope, 40 (Dec)

#### **GERIATRICS**

B.C. senior citizens receive instruction in home nursing, 7 (Nov)

VON coordinates health care for seniors, (Prime), 44 (Feb)

Ontario RNs attend workshop to improve long-term care, 12 (Jan)

Perceptual style and the adaptation of the aged to the hospital environment, (Steels), (abst), 50 (Mar)

### GIESBRECHT, Edith

MARN Board of Directors, 39 (Aug)

#### GILCHRIST, Joan M.

Freedom: an outmoded tradition, 25 (Apr)

## GIRARD, Alice

Retired, (port), 46 (Sep)

## GODARD, Jean

Bk. rev., 52 (Sep)

#### GODFREY, Madeline

Alberta nurse honored, (port), 38 (Aug)

## GOTTLIEB, Laurie Naomi

CNF scholarship, I2 (Sep)

## GOWER, Philip

Bk. rev., 54 (Apr)

#### GRAHAM, Lois E.

Dean of nursing at U. of New Brunswick, (port), 45 (Sep)

## GRANT MacEWAN COMMUNITY COLLEGE

Appointments, 45 (Jan)

#### GREENWOOD, Eileen

Serving with CARE-MEDICO in Surakarta, (port), 26 (Oct)

## GUPTA, Anna

Bk. rev., 43 (Aug)

## **GUTHRIE**, Margaret

Cardiac surgery in the first person, 31 (Sep)

Н

#### HANDICAPPED

Good way to help the handicapped, 39 (Jul)

Handicapped children learn written communication, (Maser), 29 (Aug)

Independence for phocomelic children. (Côté), 19 (Dec)

## HANNA, Anne

Writer-editor for CNA, 44 (Sep)

#### HARDY, Margaret

Vice-president of Permanent Commission and International Association of Occupational Health, 47 (May)

#### HARRISON, Fernande P.

A conceptual model for the provincial nursing consultant in Alberta, (abst), 50 (Apr)

#### HARRISON, Kay

Staff at McMaster University School of Nursing, 47 (Jan)

#### HARRISON, Mary K.

Bk. rev., 53 (Apr)

#### HART, Dorothy

Honored by Middlesex-London District Health Unit, (port), 45 (Sep)

#### HAY, Patricia

Director of nursing service at Women's College Hospital, Toronto, (port), 49 (Mar)

#### **HEALTH ACTION '72**

CNA directors at work . . . , 18 (Mar)

#### HEALTH AND WELFARE CANADA

CNA, CMA, CHA joint committee presents brief to health minister, 9 (Apr)

Beverly Witter Du Gas appointed chief of health manpower planning division. health programs branch, (port), 44 (Jun)

Elizabeth McCue retired, (port), 45 (Sep) Health care at Toronto International airport, (Starr), 32 (Feb)

Huguette Labelle principal nursing officer, (port), 47 (Feb)

Judy Hill died in wreckage of a chartered aircraft 47 (Feb)

Nurses model latest fashion, 16 (May) Rose Imai nursing consultant, health man-

Rose Imai nursing consultant, health ma power services, (port), 26 (Oct)

### **HEALTH CARE**

CNA, CMA, CHA joint committee presents brief to health minister, 9 (Apr)

MARN responds to government white paper on health policy, 16 (May)

SRNA, SMA, SHA conference supports joint health planning, 17 (Jun)

Basic health care changes needed nurse tells physicians' meeting, 7 (Nov)

A glimpse of nursing in Cuba, (Mussallem), 23 (Sep)

Health and community information services, (Kibzey), 39 (Mar)

## **HEALTH EDUCATION**

Physical fitness of children leaves much to be desired physician tells audience, 11 (Jan) Saskatchewan workshop asks how nurses rate as educators, 14 (Feb)

#### HEALTH FACILITIES

B.C. regional hospital districts name RNs to advisory committees, 12 (Oct)

#### HEALTH MANPOWER

CNA directors at work... 11 (Jun)
RNABC statement urges halt to unplanned proliferation of health workers,
15 (May)

## HEALTH SCIENCES CENTRE. WINNIPEG

New appointments, 24 (Oet)

#### HEART AND HEART DISEASES

Cardiae surgery in the first person. (Guthrie), 31 (Sep)

Coronary patients and their families receive incomplete care, (Royle), 21 (Feb)
New technique helps children, 40 (Dec)
Peghoard as space saver, (Wendril), 43
(Feb)

#### HENDERSON, Jane

CNA gets ready for the day when Canada goes metric, 10 (Jul)

Basic health care changes needed nurse tells physicians' meeting, 7 (Nov)

How CNF scholars are selected, (Archibald), 33 (May)

#### HENRY, Avis

Director of nursing for Firestone Plantations Company nursing service in Liberia. West Africa, (port), 48 (Mar)

#### HEPATITIS

Viral hepatitis — a risk to nurses, (Frye), (port), 33 (Jul)

## HERLIHY, Catherine Gerard, Sister

Honorary LLD from Saint Mary's University, 17 (Jul)

#### HIBBERT, Jessie

Appointed to mental health advisory council of Alberta, 36 (Nov)

#### HILL, Judith

Memorial fund set up in name of Judith Hill, 10 (May) Obit, 47 (Feb)

#### HILTON, Barbara Ann

CNF scholarship, 12 (Sep)

#### HINDLE, Judith

Bk. rev., 41 (Jul)

## **HOEFFLER**, Deborah Margaret

A survey to determine the perceptions of a selected group of head nurses and supervisors concerning the channels of communication existing within a hospital (abst), 50 (Apr)

## HOFFMEYER, Cheryl

Staff at Grant MacEwan Community

College. (port), 46 (Jan)

#### HOLDER, Elizabeth Lorraine

Awarded Volunteer Nursing Services Bursary from the Canadian Red Cross Society, 47 (Mar)

## **HOLDER**, Janet Margaret

CNF scholarship, 12 (Sep)

## HOLLAND, Gillian

Drink up a tune, 39 (Sep)

#### HOOD, Phyllis M.

CNF scholarship, 12 (Sep)

## HOOTON, Margaret

Bk. rev., 49 (May)

#### HORROCKS, Mona June

Faculty Dalhousie University school of nursing, 42 (Dec)

#### HORTON, Leslie

What will happen to Mr. Lang? 39 (May)

## HOSPITAL EMERGENCY SERVICE

Help in a hurry: the erisis clinic, (Mary Mona), 35 (Oct)

#### HOSPITAL FOR SICK CHILDREN, TORONTO

Children's hospital opens units for patients and their mothers, 15 (Oct)

New technique helps children, 40 (Dec)

Three Toronto institutions unite to help prevent child abuse, 18 (Jan)

#### HOSPITAL NURSING SERVICE

Staff nurse involvement in research—myth or reality? (Stinson), 28 (Jun)

A survey to determine the perceptions of a selected group of head nurses and supervisors concerning the channels of communication existing within a hospital, (Hoeffler), (abst), 50 (Apr)

## HOSPITALS

ANPQ recommendations included in Quebec hospital regulations, 8 (Feb)

B.C. regional hospital districts name RNs to advisory committees, 12 (Oct)

## HOWARD, Frances

Problem-oriented charting—a nursing viewpoint, (Jessop), 34 (Aug)

## HOWEY, Mary C.

Campus head at Mohawk College dept, of nursing, 42 (Dee)

## HOYT, Bonny

Bk. rev., 50 (Dec)

## **HUMAN RELATIONS**

Bill of rights for patients to be established in N.S., 19 (Mar)

Crisis intervention after the hirth of a defective child, (Stanko), 27 (Jul)

Patients' representative humanizes hospi-

tal stay, 16 (Oct)

Philosophy of life, (Lindabury), (edit), 3 (Jan)

Who are these people? (McKone), 44 (Oct)

#### **HUTCHINGS**, Jane Clouston

Member of Order of Canada, 48 (Apr)

#### **HUTCHINSON**, Grace

Elected to SRNA council, 44 (Sep)

#### HYPOGLYCEMIA

Hypoglycemia, (Wolfe, Powers), 38 (Oct)

#### IMAI, Rose

Nursing consultant, health manpower services, Health and Welfare Canada, (port), 26 (Oct)

#### **IMMUNIZATION**

Health care at Toronto International Airport, (Starr), 32 (Feb)

#### IN A CAPSULE

46 (Feb) 46 (Apr), 42 (Jun), 39 (Jul), 40 (Aug), 48 (Oct), 40 (Dec)

## INDEXES AND INDEXING

The Canadian Nurse one of six nursing journals indexed 11 (Jan)

#### INFANTS

Whose haby is this? (Baizley), 27 (Mar)

#### L'INFIRMIERE CANADIENNE

CNA directors at work . . . 18 (Mar)

#### **INFLUENZA**

The pandemic influenza of 1918, (Morton), 25 (Dec)

### INFORMATION SERVICES

Health and community information services, (Kibzey), 39 (Mar)

#### INJECTIONS

Acupuncture, (Armstrong), 26 (Feb) Intravenous hyperalimentation, (Deitel), 38 (Jan)

## **INSERVICE EDUCATION**

Hold a fair, stock a cart: for inservice education, (Allen), 38 (Sep)

#### INTENSIVE CARE UNITS

Daily ICU conference improves patient care, 37 (Mar)

### INTERNATIONAL ASSOCIATION FOR MEDICAL ASSISTANCE TO TRAVELLERS

Hometown medical care provided around the world by IAMAT, 12 (Oct)

#### INTERNATIONAL COUNCIL OF NURSES

ICN code for nurses: ethical concepts applied to nursing, 9 (Aug)

by ICN committee, 16 (Dec)

Code for nurses among topics discussed

Daisy Bridges, (Lindabury), (Edit), 3 (Feb) Daisy Bridges obit, 47 (Feb)

Executive director emphasizes student participation, 14 (Mar)

International nurses' day focuses on the environment, 9 (May)

New board and committee elected at ICN Congress, 9 (Jul)

Nicole Du Mouchel elected to 11-member board of directors, (port), 16 (Jul)

Plans celebration for 75th anniversary in 1974, 8 (Oct)

South Africa Nursing Association must try to change law by '75: ICN, 7 (Jul)

## INTERNATIONAL COUNCIL OF NURSES. BOARD OF DIRECTORS

Officers elected, 16 (Jul)

## INTERNATIONAL COUNCIL OF NURSES. COMMITTEE ON LIBRARY RESOURCES FOR NURSING

CNA in favor, 11 (Mar)

## INTERNATIONAL COUNCIL OF **NURSES. CONGRESS 1973**

ICN meets in Mexico, (Starr), 17 (Aug) Canadians on ICN committees ready reports for 1973 congress, 11 (Mar) Editorial, (Starr), 3 (Aug) Nurses across Canada plan four panels for ICN Congress, 9 (Apr) Preparing for ICN, 46 (Feb)

## INTERNATIONAL COUNCIL OF **NURSES. CONGRESS 1977**

Next ICN Congress in Japan, 12 (Jul)

## INTERNATIONAL NURSING INDEX

The Canadian Nurse one of six nursing journals indexed, 11 (Jan)

## INTERNATIONAL NURSING REVIEW

Merren Tardivelle editor, (port), 46 (Mar)

#### INTERVIEWING

The nurse in a student physician's "practice," (Valberg), 17 (Nov)

Student nurses share in clinical learning, (Corbett), 21 (Nov)

#### IRVING, Mary

Director of nursing service, Hotel Dieu Hospital, Chatham, N.B., 38 (Aug)

#### IRWIN, Eileen Dauphinee

Faculty Dalhousie University school of nursing, 42 (Dec)

#### IRWIN, Helen Roberta

Kathleen Ellis prize, (port), 16 (Jul)

#### IVES, Jennie E.

Retired, 45 (Sep)

1

#### JACKSON, Marion

Nursing administrator at Saskatoon City

Hospital, (port), 44 (Jun)

## JACKSON, Marjorie

Honorary member of MARN, (port), 38 (Aug)

## JAMESON, E.E. (Jamie)

Retired as director of nursing education at Calgary General Hospital, (port), 46 (Sep)

#### JANZOW, Esther

District director of Victoria Branch of VON, 26 (Oct)

## JESSOP, Penelope I.

Problem-oriented charting - a nursing viewpoint, (Howard), 34 (Aug)

#### JOHNSON, Grace

Retired as consultant in nursing services, Dept. of Veterans Affairs, 39 (Aug)

#### KARLINSKY, Norma

Bk. rev., 43 (Jul)

Faculty University of Calgary, School of Nursing, (port), 47 (May)

#### KEITH, Catherine W.

Received merit award, (port), 46 (Sep)

#### KERGIN, Dorothy

Changing nursing practice through education, (et al), 28 (Apr)

#### KIBZEY, Heather

Health and community information services, 39 (Mar)

#### KIDNEY FOUNDATION OF CANADA

Program offers wallet-size donor cards, 20 (May)

## KIDNEYS

Do-it-yourself dialysis, (Schaffer), 29 (Jul)

Bk. rev., 52 (Mar)

## KISSEIH, Docia

First vice-president ICN, 16 (Jul)

## KNOR, Emily

Staff at Grant MacEwan Community College, (port), 46 (Jan)

#### KOCH-SCHULTE, Ruth

Three Toronto institutions unite to help prevent child abuse, 18 (Jan)

#### KOHAN, Rita

Employment relations dept. RNAO, 41 (Dec)

L

## LABELLE, Huguette

CNA Pres.-elect tells RNAO society needs

coping resources, 10 (Jul)

Principal nursing officer with Dept. of National Health and Welfare, (port), 47 (Feb)

#### LABOUR SUPPLY

AARN says nurses' jobs available in Alberta, 12 (Mar)

#### LABOUR UNIONS

SRNA Exec. secretary summonsed before labor relations board, 12 (Jan)

Arbitration backs nurse's claim to bonus for midwifery course, 18 (Apr)

Nipawin nurses challenge order of Sask. labor relations board, 11 (Mar)

Nurse with cast on leg can't work arbitration board rules, 20 (Mar)

Practical nurses at B.C. hospital win equal pay for equal work, 15 (Sep)

Sask. labor relations board told to rehear nurses' application, 16 (Jun)

#### LAGERSON, Joanne

Spotlight on the clinical nurse specialist, (Dworkin), 42 (Sep)

#### LAING, Gail

Bk. rev., 53 (Sep)

#### LAKEHEAD UNIVERSITY

Appointments in school of nursing, 48 (Mar)

University schools of nursing in Canada, 23 (Jan)

#### LALANCETTE, Denise

English visitor meets clinical specialists at CNA House, (port), 48 (Mar)

## LAMBIE, Elizabeth

Bk. rev., 49 (May)

## LAMBETH, Dorothy

Chairman of dept. of nursing at Mohawk College, Hamilton, (port), 42 (Dec)

#### LAMOTHE, Rachel

Teaching nursing at CEGEP in Three Rivers, P.Q., (port), 44 (Sep)

#### LARACY, Pauline

Retired, 36 (Nov)

## LARSEN, Jenneice

Staff at Grant MacEwan Community College, (port), 46 (Jan)

#### LaSOR, Betsy

Bk. rev., 53 (Apr)

#### LAUGHARNE, Elizabeth

Gestational diabetes — when teaching is important, (Duncan), 34 (Mar)

## LAURENTIAN UNIVERSITY

Alma Elizabeth Reid acting director of school of nursing, 43 (Dec)

Faculty appointments school of nursing, 43 (Dec)

University schools of nursing in Canada, 23 (Jan)

#### LAVAL UNIVERSITY

University schools of nursing in Canada, 23 (Jan)

#### LAW AND LEGISLATION

ANPQ goals reflected in new Quebec legislation, 7 (Aug)

ANPQ recommendations included in Quebec hospital regulations, 8 (Feb)

CNA directors at work . . . , 17 (Mar)

1,755 nurses discuss legislation at ANPQ meeting via phone relays, 10 (Jun)

## LEASK, Jean

CNA honors Jean Leask on her retirement, (port), 46 (Mar)

Named Officer of the Order of Canada, 24 (Oct)

#### LEDINGHAM, Rita

Elected to SRNA council, 44 (Sep)

### LEE, Barbara Herrick

Bk. rev., 57 (Sep)

## LEE, Margaret

Resigned as director of Laurentian University school of nursing, 43 (Dec)

#### LENCZNER, Michael M.

Tropical and parasitic diseases: new challenge to health teams, 34 (Sep)

#### LENHARDT, Jane K.

Bk. rev., 48 (May)

#### LETTERS

4 (Jan), 4 (Feb), 4 (Mar), 4 (Apr), 4 (May), 4 (Jul), 4 (Aug), 4 (Sep), 4 (Oct), 4 (Nov), 4 (Dec)

#### LEVINE, Myra E.

RNAO told confusion of goals prevents nursing communication, 10 (Jul)

#### LIBRARIES

CNA in favor of ICN Committee on Library Resources for Nursing, 11 (Mar)

## LICENSURE

Professionalism in nursing, (Valentine), (abst), 50 (Oct)

## LINDABURY, Virginia A.

Canada pension plan discriminates, (edit), 29 (Oct)

The case of the tobacco leaves, (edit), 3 (Nov)

Daisy Bridges, (edit), 3 (Feb)

Jeanne Mance, (edit), 3 (Apr)

Obituaries, (edit), 3 (Jun)

Pensions, (edit), 3 (Oct)

Philosophy of life, (edit), 3 (Jan) Physicians' assistants, (edit), 3 (May)

Road accidents, (edit), 3 (Jul)

#### LOCKEBERG, Liv-Ellen

All in the day's work . . . 33 (Jun)

Editorial, 3 (Sep)

## LOCKING, Heather

Staff at Queen's University school of nursing, 41 (Dec)

#### LOISELLE, YVETTE

Superintendent-in-chief of St. John Ambulance Brigade in Canada, (port), 47 (Mar)

### LOVERING, Bernice

Bk. rev., 54 (Mar)

## LOYER, Marie A.

Bk. rev., 54 (Oct)

## LUCAS, Bessie

Retired, (port), 42 (Dec)

#### LYTTLE, Phyllis

Retired as director of public health nursing, Nova Scotia dept. of public health, (port), 48 (Apr)

M

### **MEDLARS**

The Canadian Nurse one of six nursing journals indexed, 11 (Jan)

#### MEDLINE

The Canadian Nurse one of six nursing journals indexed 11 (Jan)

#### McBRIDE, Beverley

A new method of tubal ligation, 32 (Apr)

#### McCANN, Beverley M.

Bursary from Ontario division of Volunteer Nursing Service Committee of Canadian Red Cross Society, 36 (Nov)

## McCARTHY, Ellen

Staff at Queen's University school of nursing, 41 (Dec)

#### McCLELLAND, Audrey

MARN Board of Directors, 39 (Aug)

#### McCLURE, Lynn

Second vice-president of MARN, (port), 39 (Aug)

## McCONE, Carol

Preadmission patient teaching clinic, 39 (Sep)

#### McCRADY, Margaret

Staff Health Sciences Centre, Winnipeg, (port), 24 (Oct

## McCUE, Elizabeth

Retired, (port), 45 (Sep)

## McCULLAGH, L. Joan

Assistant director of education services at RNABC, (port), 36 (Nov)

#### McEWAN, Ada E.

National director of VON, (port), 46

(Mar)

A study of the attitudes of public health nurses as they affect the teaching of family planning, (abst), 48 (Sep)

#### McGILL UNIVERSITY

Colloquium on nursing research held at McGill University, 13 (Jun)

University schools of nursing in Canada, 23 (Jan)

#### McGRAW, Des Ange

NBARN scholarship, 42 (Dec)

#### McGRAW, Rosa

NBARN scholarship, 42 (Dec)

## McINNES, Betty

Bk. rev., 48 (Jan)

#### MacINTOSH, Mary, Sister

Retires as director of St. Rita Hospital School of Nursing, Sydney, Nova Scotia, 46 (Sep)

### McINTYRE, Evelyn

Health care at Toronto International Airport, (Starr), 32 (Feb)

#### McINTYRE, LOUISE

Associate employment relations officer for New Brunswick Nurses Provincial Collective Bargaining Councils, 45 (Jan)

#### MacKAY, Jane

Elected to SRNA council, 44 (Sep)

#### MacKAY, Ruth

Staff at McMaster University School of Nursing, 47 (Jan)

## McKENDRY, J.B.R.

Idiopathic edema, 41 (May)

#### McKIERNAN, Frances, Sister

Faculty Dalhousie University school of nursing, 42 (Dec)

#### MacKINNON, Alice R.

Registrar of AARN, (port), 39 (Aug)

#### McKINNON, Barbara, Sister

Director of nursing service, St. Joseph's General Hospital, Thunder Bay, (port), 48 (Feb)

#### McKNIGHT, Wendy

Staff at Queen's University school of nursing, 41 (Dec)

#### McKONE, Alma

Who are these people? 44 (Oct)

#### McLEAN, Margaret D.

Director of School of Nursing, Memorial University of Newfoundland, (port), 44 (Sep)

#### McLELLAN, Elsie I,

Patients' recreational program, 37 (Mar)

#### McLELLAN, Tina Orser

NBARN scholarship, 42 (Dec)

#### MacLENNAN, E.A. Electa

Life membership in Atlantic region CAUSN, 17 (Jul)

#### MacLEOD, Ella

Appointed to PEI Civil Service Commission, (port), 43 (Jun)

## MacLEOD, Mary, Sister

Director of St. Rita Hospital School of Nursing, Sydney, Nova Scotia, 46 (Sep)

## McLEOD, Mona

Bk. rev., 56 (Sep)

#### McMASTER UNIVERSITY

Appointments, 46 (Jan)

Changing nursing practice through education, (Kergin et al), 28 (Apr)

Master of health sciences program will prepare nurses at McMaster, 10 (Apr) University schools of nursing in Canada, 23 (Jan)

### McNEIL, Pauline

Travels with a nurse in rural Nova Scotia, (port), 20 (May)

#### MacNEILL, Susan Elizabeth

Faculty Dalhousie University school of nursing, 42 (Dec)

## McPHEDRAN, Margaret G.

On teaching staff at U. of New Brunswick, (port), 45 (Sep)

#### McPHEE, Aleen

Appointed coordinator of nursing care project in Vernon, B.C., 45 (Sep)

#### MAHLER, H.

Director-general of WHO, 26 (Oct)

## MAJUMDAR, Basanti

Bk. rev., 52 (Oct)

## MANCE, Jeanne

Government issues stamp to honor Jeanne Mance, 10 (Apr)

Jeanne Mance, (Lindabury), (edit), 3 (Apr) Reception in honor of new Jeanne Mance stamp, 6 (Jun)

Stamp in April, 12 (Jan)

## MANITOBA ASSOCIATION OF REGISTERED NURSES

Allan Rosky associate employment relations adviser, 41 (Dec)

Board of directors, 39 (Aug)

David G. Sparkes employment relations officer, 43 (Jun)

Lynn McClure second vice-president, (port), 39 (Aug)

Marjorie Jackson honorary member, (port), 38 (Aug)

Responds to government white paper on health policy, 16 (May)

Sr. Therese Carignan executive director, (port), 47 (Feb)

#### MAQUERA, Myrna

Staff at Grant MacEwan Community College, (port), 46 (Jan)

#### MARTIN, Barbara

Staff at Queen's University school of nursing, 41 (Dec)

#### MARTIN, Ellen

Staff at Grant MacEwan Community College, (port), 45 (Jan)

#### MARY ELAINE, Sister

Director of nursing at St. Mary's of the Lake Hospital, Kingston, Ont., (port), 26 (Oct)

#### MARY MONA, Sister

Help in a hurry: the crisis clinic, 35 (Oct)

#### MASER, Earl

Handicapped children learn written communication, 29 (Aug)

#### MASSAGE

Acupuncture, (Armstrong), 26 (Feb)

## MATIKO, Mary G.

Bk. rev., 51 (Mar)

#### MAUS, Elisabeth M.

Campus head at Mohawk College dept. of nursing, 42 (Dec)

#### MEDICAL CARE

Hometown medical care provided around the world by IAMAT, 12 (Oct)

## MEDICAL RESEARCH COUNCIL

Jo-Ann Tippett Fox awarded studentship, 26 (Oct)

## MEILICKE, Dorothy T.

Surgical separation of conjoined twins, (Dirksen), 26 (May)

## MEMORIAL UNIVERSITY OF NEWFOUNDLAND

Margaret D. McLean director, (port), 44 (Sep)

University schools of nursing in Canada, 23 (Jan)

## MENTAL HEALTH

A multidimensional analysis of role perception in a mental health system, (Riddell), (abst), 48 (Sep)

#### MENTAL RETARDATION

A survey of Canadian schools of nursing to determine the instruction and clinical experience provided in mental retardation, (Pearen), (abst), 50 (Oct)

## MERCIER, Olive

Director of nursing at French-language school of nursing, Edmunston, N.B., 43 (Dec)

#### METRIC SYSTEM

CNA gets ready for the day when Canada goes metric, 10 (Jul)

## METROPOLITAN (DEMONSTRATION) SCHOOL OF NURSING

CNA demonstration nursing school celebrates 25th anniversary, 7 (Aug)

#### MICHENER, Roland

Opened the National Conference on Fitness and Health, (port), 11 (Jan)

#### MICROBIOLOGY

How to make microbiology interesting for students, (Murray), 37 (Jul)

#### MIDWIFERY

CNA supports RNAO statement on nursemidwifery, 7 (Dec)

RNAO accepts statement on role and functions of nurse midwife, 12 (Jul)

Arbitration backs nurse's claim to bonus for midwifery course, 18 (Apr)

Professional midwives can care for majority of all deliveries, 13 (Jan)

#### MILITARY NURSING

Nicole Du Mouchel promoted to rank of major in the Canadian Forces Reserve, (port), 36 (Nov)

#### MISERICORDIA GENERAL HOSPITAL

Daily ICU conference improves patient care, 37 (Mar)

## MITCHELL, Eleanor

Director of volunteer nursing services of Ontario division of Canadian Red Cross, 36 (Nov)

#### MITRA, Carmen

Bk. rev., 54 (Apr)

#### MOHAWK COLLEGE, HAMILTON

Campus heads of dept, of nursing, 42 (Dec) Dorothy Lambeth chairman of dept. of nursing, (port), 42 (Dec)

## MONARDEZ, Iris

Staff of ICN, 47 (Mar)

## MONEO, Jean

SRNA bursary, 47 (Mar)

## MONIER-WILLIAMS, Joan

Retired as director of Canadian Mothercraft Society, Ottawa branch, 24 (Oct)

## MORAN, Lucille

Bk. rev., 52 (Sep)

#### MORGAN, Margaret P.

Campus head at Mohawk College dept. of nursing, 42 (Dec)

#### MORLEY, Margaret H.

Decubitus ulcer management — a team approach, 41 (Oct)

#### MORTON, Gladys

The pandemic influenza of 1918, 25 (Dec)

## MOUNT SAINT VINCENT UNIVERSITY

University schools of nursing in Canada, 23 (Jan)

#### MOUNT SINAI HOSPITAL. TORONTO

Queen talks with nursing students, 7 (Aug)

#### MUMBY, Dorothy

Lenna Richardson honored at retiement, (port), 41 (Dec)

#### MURRAY, Joe Anne

How to make microbiology interesting for students, 37 (Jul)

#### MUSCLES

Myasthenia gravis, (Stackhouse), 28 (Dec)

#### MUSSALLEM, Helen K.

CNA executive director advises school of nursing in Uruguay, 7 (Oct)

A glimpse of nursing in Cuba, 23 (Sep) Guess who's coming to lurch? (port),

7 (Nov)

Keynote speaker at ARNN meeting has

Advice for associations, 8 (Nov)

Latin American nurses consider middle level nursing education, 14 (Jan)

National Conference on Fitness and Health, (port), 11 (Jan)

Promoted to Commander Sister, (port), 47 (Feb)

#### N

### NAMES

45 (Jan), 47 (Feb), 46 (Mar), 48 (Apr), 47 (May), 43 (Jun), 16 (Jul), 38 (Aug), 44 (Sep), 24 (Oct), 36 (Nov), 41 (Dec)

## NATIONAL CONFERENCE ON FITNESS AND HEALTH

Fitness and health conference aims at fitness for all Canadians, 8 (Feb)

Physical fitness of children leaves much to be desired physician tells audience, 11 (Jan)

Roland Michener opened conference, (port), 11 (Jan)

Work is a basic biologic need Selye tells fitness conference, 10 (Feb)

## NATIONAL CONFERENCE ON SCHOOL HEALTH

CNA executive approves responses to school health recommendations, 7 (Feb)

#### NAUM, Helen

Honorary membership in CAUSN (Atlantic), 17 (Jul)

#### NEUFELD, Hildy

Assistant director St. Boniface General Hospital School of Nursing, St. Boniface, Man., (port), 49 (Mar)

#### NEUROLOGY

Myasthenia gravis, (Stackhouse), 28 (Dec) Neuro nurses sponsor contest for student nurses in Canada, 14 (Jan)

#### NEUROSURGICAL NURSING

Neurosurgical nurses of world federate, plan 1973 meeting, 14 (Mar)

#### NEVITT, Joyce

Fellow of Royal Society of Health, (port), 47 (Mar) Sabbatical leave, (port), 44 (Sep)

## NEW BRUNSWICK ASSOCIATION OF REGISTERED NURSES

Antoinette Bourgeois awarded scholarship, 44 (Jun)

Committee on education of nurses named to advise NBARN council, 12 (Aug)

Invited to be represented on N.B. Council on Smoking, 12 (Oct)

Life memberships, 16 (Jul)

Members at NBARN annual meeting support various recommendations. 8 (Sep)

New entrance procedure adopted for N.B. diploma schools, 10 (May)

Report to guide nurses who encounter drug problems, 9 (Oct)

Representative of public named to NBARN governing body, 15 (May)

Scholarships awarded, 42 (Dec)

## NEW BRUNSWICK NURSES PROVINCIAL COLLECTIVE BARGAINING COUNCILS

Grace Stevens retires as associate employment relations officer, 45 (Jan)

Louise McIntyre appointed associate employment relations officer, 45 (Jan)

#### NEW PRODUCTS

49 (Feb), 42 (Mar), 22 (Apr), 45 (May), 18 (Jun), 13 (Jul), 18 (Sep), 16 (Oct), 44 (Dec)

## **NEWS**

11 (Jan), 7 (Feb), 11 (Mar), 9 (Apr), 9 (May), 5 (Jun), 7 (Jul), 7 (Aug), 7 (Sep), 7 (Oct), 7 (Nov), 7 (Dec)

#### **NICARAGUA**

Canadian nurses with CARE help injured in Nicaragua, 14 (Feb)

#### NIELSEN, Ann Margaret Winter

Faculty Dalhousie University school of nursing, 42 (Dec)

## NIGHTINGALE SCHOOL OF NURSING. TORONTO

Queen talks with nursing students, 7 (Aug)

#### NIGHTINGALE, Helen (Leni)

Director of nursing Brockville Psychiatric Hospital, (port), 44 (Jun)

## NORRIS, Catherine M.

Delusions that trap nurses . . , 37 (Jun)

### NORTHWEST TERRITORIES REGISTERED NURSES' ASSOCIATION

Registered nurses' association formed in Northwest Territories, 13 (Jun)

## NOVA SCOTIA. DEPT. OF PUBLIC HEALTH

Travels with a nurse in rural Nova Scotia, 20 (May)

### NOVA SCOTIA. HEALTH COUNCIL ON HEALTH CARE

RNANS members critical of report, 9 (Sep)

## NOVA SCOTIA. HEALTH SERVICES COMMISSION

N.S. government appoints nurse to health services commission, 12 (Nov)

Muriel E. Small appointed, (port), 36 (Nov)

#### NUGENT, E. Margaret

Staff Health Sciences Centre, Winnipeg, (port), 24 (Oct)

#### NURSE-PATIENT RELATIONSHIP

The patient as an equal partner, (Ujhely), 21 (Jun)

#### NURSES' CENTRAL SECURITY FUND

RNAO supports central union to replace bargaining units, 8 (Jul)

#### NURSES, INTERCHANGE OF

Memorial fund set up in name of Judith Hill, 10 (May)

#### NURSING

Delusions that trap nurses...(Norris), 37 (Jun)

## NURSING — DEFINITIONS

ANPQ success in defining nursing explained at CNA annual meeting, 5 (Jun)
ICN meets in Mexico, (Starr), 17 (Aug)
Members at NBARN annual meeting support various recommendations, 8 (Sep)

#### NURSING — TRENDS

CNA directors at work . . . , 18 (Mar), 11 (Jun)

CNA policy statements on the primary care nurse, 13 (Jun)

RNABC brief urges program to prepare nurses for new roles, 14 (Apr)

RNANS members critical of report of N.S. Council on Health Care, 9 (Sep)
The expanded role of the nurse: a joint

statement of CNA/CMA, 23 (May)

Expanding role of nurses stressed at RNABC meeting, 13 (Aug)

Pay for nurse in expanded role should be

salary, not fee: CNA, 11 (Mar) Workshop on nurse practitioner shows cooperation in N.B., 15 (Aug)

NURSING — CUBA

A glimpse of nursing in Cuba. (Mussallem), 23 (Sep)

#### NURSING — GREAT BRITAIN

See also Physicians' assistants.

Nurses in Great Britain protest proposed salaries in national health service, 15 (Oct)

#### NURSING — ST. LUCIA

West Indian nurses enjoy Canadian nursing books, 8 (Feb)

#### NURSING — URUGUAY

CNA executive director advises school of nursing in Uruguay, 7 (Oct)

#### NURSING CARE

Daily ICU conference improves patient care, 37 (Mar)

Decubitus ulcer management — a team approach, (Morley), 41 (Oct)

Problem-oriented charting—a nursing viewpoint, (Howard, Jessop), 34 (Aug)

#### NURSING HISTORY

Jeanne Mance, (Lindabury), (edit), 3 (Apr) Nursing history references, 54 (Oct) Red Cross outpost nursing in New Brunswick, (DeMarsh), 24 (Jun)

#### NURSING HOMES

Ontario RNs attend workshop to improve long-term care, 12 (Jan)

#### NURSING MANPOWER

B.C. Hospitals need more nurses to avoid summer staffing problems, 16 (May) CNA directors at work . . . 12 (Jun) Shortage of nurses exists in some provinces, 7 (Feb)

#### NUTRITION

Intravenous hyperalimentation, (Deitel), 38 (Jan)

Trace elements in food, (Clegg, Sandi), 38 (Feh)

#### O

## **OBITUARIES**

Editorial, (Lindabury), 3 (Jun)

## **OBSTETRICS**

Crisis intervention after the birth of a defective child, (Stanko), 27 (Jul)

Gestational diabetes — when teaching is important, (Laugharne, Duncan), 34 (Mar)

Inside dope, 40 (Dec)

## OCCUPATIONAL HEALTH NURSING

All in the day's work . . . (Lockeberg), 33 (Jun)

Health care at Toronto International Airport, (Starr), 32 (Feb)

#### O'CONNOR, Carolyn

Faculty Laurentian University school of nursing, 43 (Dec)

## OFFICIAL DIRECTORY

72 (Apr), XXIV (Dec)

#### OGILVIE, Heather

Staff at Queen's University school of nursing, 42 (Dec)

## OKA, Betty

Staff at McMaster University School of Nursing, 47 (Jan)

#### OLIVER, Sharon

Lecturer at Lakehead University, 49 (Mar)

#### O'NEIL, Sheila Marie

CNF scholarship, 12 (Sep)

#### ONTARIO HEART FOUNDATION

Offers fellowship for master's degree, 17 (Feb)

### ONTARIO NURSES' ASSOCIATION

Formed for province-wide bargaining, 15 (Dec)

#### ORDER OF CANADA

Jean Leask named Officer, 24 (Oct)

## ORDER OF NURSES OF THE PROVINCE OF QUEBEC

Editorial, (Lockeberg), 3 (Sep)
See also Association of Nurses of the
Province of Quebec

#### ORDER OF ST. JOHN

Investiture, 47 (Feb)

## OVERSEAS BOOK CENTRE OF CANADA

West Indian nurses enjoy Canadian nursing books, 8 (Feb)

## OWEN SOUND REGIONAL SCHOOL OF NURSING

Exotic foods part of course for nursing students, 11 (Jul))

## P

## PACY, Hanns

First aid for drivers, 23 (Jul)

## PALLISTER, Ruth M.

Bk. rev., 38 (Nov)

Staff at McMaster University School of Nursing, 47 (Jan)

## PAN AMERICAN HEALTH ORGANIZATION

Latin American nurses consider middle level nursing education, 14 (Jan)

#### PARKER, Nora I.

The effects of error modeling on the learning of a complex procedure in nursing, (abst), 50 (Fcb)

#### PATCHING, Donna

Staff at Grant MacEwan Community College, (port), 46 (Jan)

#### PATERSON, Richard

Staff Health Sciences Centre, Winnipeg, (port), 24 (Oct)

#### PATIENT CARE TEAM

Decubitus ulcer management — a team approach, (Morley), 41 (Oct)

#### **PATIENTS**

Bill of rights for patients to be established in N.S., 19 (Mar)

Controlling the fight/flight patient, (Reid), 30 (Oct)

A diabetic teaching tool, (Skelton), 35 (Dec)

The patient as an equal partner, (Ujhely), 21 (Jun)

Patients' recreational program, (McLellan), 37 (Mar)

Preadmission patient teaching clinic, (McCone), 39 (Sep)

What will happen to Mr. Lang? (Horton), 39 (May)

#### PAULSON, Sylvia Diane

Assistant professor, U. of British Columbia, School of Nursing, 36 (Nov)

#### PEAREN, Elsie I.E.

A survey of Canadian schools of nursing to determine the instruction and clinical experience provided in mental retardation, (abst), 50 (Oct)

## **PEDIATRICS**

Children's hospital opens units for patients and their mothers, 15 (Oct)

New technique helps children, 40 (Dec)

## PENSIONS

Canada pension plan discriminates, (Lindabury), (edit), 29 (Oct)
Editorial, (Lindabury), 3 (Oct)

#### PEPLER, Carolyn

Bk. rev., 53 (Oct)

#### PHILATELY

Government issues stamp to honor Jeanne Mance, 10 (Apr)

Jeanne Mance stamp in April, 12 (Jan)

Reception in honor of new Jeanne Mance stamp, 6 (Jun)

#### PHYSICIANS' ASSISTANTS

Editorial, (Lindabury), 3 (May) See also Nursing — Trends

#### PICKARD, Audrey E.

Bk. rev., 52 (Apr)

Faculty Laurentian University school of nursing, 43 (Dec)

#### PICKETTS, Pat

Staff at Grant MacEwan Community College, (port), 45 (Jan)

#### PILL, Miriam

Bk. rev., 49 (Jan)

#### PLUMER, Susan

NBARN scholarship, 42 (Dec)

#### **POISONS**

Are your plants toxic? 40 (Dec) Health food poisonings, 46 (Apr)

#### POOLE, Pamela

Canadian nurse admitted to nurse researchers' group, 12 (Aug)

## POTTER, Thelma I.

Bk. rev., 49 (Dec)

#### POWER, Denise Mary

Faculty Dalhousie University school of nursing, 42 (Dec)

#### POWERS, Rosemary

Hypoglycemia, (Wolfe), 38 (Oct)

#### PRACTICAL NURSING

First men trained as nursing assistants in P.E.I., 13 (Aug)

First RNAs elected to council of Ontario College of Nurses, 8 (Aug)

Practical nurses at B.C. hospital win equal pay for equal work, 15 (Sep)

#### PRIME, Barbara L.

VON coordinates health care for seniors, 44 (Feb)

#### **PROFESSIONS**

Freedom: an outmoded tradition, (Gilchrist), 25 (Apr)

## PSYCHIATRIC NURSING

Controlling the fight/flight patient, (Reid), 30 (Oct)

Help in a hurry; the crisis clinic, (Mary Mona), 35 (Oct)

The influence of a human relations laboratory on the effectiveness of third-year psychiatric nurses, (Checkley), (abst), 50 (Mar)

### PUBLIC HEALTH NURSING

Car care and wilderness survival in Australian nurses' course, 14 (Apr)

First nurses' strike in Alberta ends with 24.7 percent pay increase, 8 (Aug)

Red Cross outpost nursing in New Brunswick, (DeMarsh), 24 (Jun)

Street nurses in blue jeans, (Ruiterman, Biette), 34 (Jan)

A study of the attitudes of public health nurses as they affect the teaching of family planning, (McEwan), (abst), 48 (Sep)

## Q

#### **OUEEN ELIZABETH**

Queen talks with nursing students, 7 (Aug)

#### QUEEN'S UNIVERSITY

Appointments to school of nursing staff, 41 (Dec)

University schools of nursing in Canada, 23 (Jan)

#### R

#### RANDALL, Lillian

Retired as district director of Victoria Branch VON, 26 (Oct)

#### RECREATION

It's a skater's show on the Rideau, (Dworkin), 32 (Dec)

Patients' recreational program, (McLellan), 37 (Mar)

#### **RED CROSS**

Ont. Red Cross Society offers bursary to nurses, 16 (Dec)

Red Cross outpost nursing in New Brunswick, (DeMarsh), 24 (Jun)

#### REGINA GENERAL HOSPITAL

Regina General Nurses' Alumnae offers graduates \$500 scholarship, 17 (Jun)

## REGISTERED NURSES' ASSOCIATION OF BRITISH COLUMBIA

B.C. hospitals need more nurses to avoid summer staffing problems, 16 (May)

B.C. nurses discuss report on community health centers, 10 (Feb)

Brief urges program to prepare nurses for new roles, 14 (Apr)

Expanding role of nurses stressed at RNABC meeting, 12 (Aug)

L. Joan McCullagh assistant director of education services, (port), 36 (Nov)

Meetings now open to observers, 13 (Jan)
Plans to add nonnurses to its board and
committees, 9 (Sep)

Seeks bargaining rights for RNs in civil service 10 (Apr)

Statement urges halt to unplanned proliferation of health workers, 15 (May)

## REGISTERED NURSES' ASSOCIATION OF NOVA SCOTIA

Annual meeting gets off to lively start, 38 (Aug)

Bill of rights for patients to be established in N.S., 19 (Mar)

Members critical of report of N.S. Council on Health Care, 9 (Sep)

Wants a commission to finance postsecondary education, 18 (Jan)

## REGISTERED NURSES' ASSOCIATION OF ONTARIO

CNA Pres.-elect tells RNAO society needs coping resources, 10 (Jul)

CNA supports RNAO statement on nursemidwifery, 7 (Dec)

Accepts statement on role and functions of nurse midwife, 12 (Jul)

It gives a lovely light! (8 (Jul)

Problems of teachers, students discussed at RNAO meeting, 8 (Jul)

Reorganized employment relations department, 41 (Dec)

School teaches nurses collective bargaining techniques, 7 (Sep)

Sponsors summer school on collective bargaining, 18 (Jan)

Supports central union to replace bargaining units, 8 (Jul)

Told confusion of goals prevents nursing communication, 10 (Jul)

Wilma Ballantyne member emeritus, 16 (Jul)

#### REHABILITATION

Argon laser photocoagulation for retinal vascular disease, (Rosen), 36 (May)

Coronary patients and their families receive incomplete care, (Royle), 21 (Feb) Talking exerciser for children, 22 (Apr)

#### REID, Alma Elizabeth

Acting director of Laurentian University school of nursing, 43 (Dec)

#### REID, Jean A.

Controlling the fight/flight patient, 30 (Oct)

#### REID, Una V.

Bk. rev., 42 (Aug)

## RESEARCH

Canadian nurse admitted to nurse researchers' group, 12 (Aug)

Changing nursing practice through education, (Kergin et al), 28 (Apr) Colloquium on nursing research held at

McGill University, 13 (Jun)

Committee appointed, priorities ranked by directors, 7 (Dec)

A conceptual model for the provincial nursing consultant in Alberta, (Harrison), (abst), 50 (Apr)

Coronary patients and their families receive incomplete care, (Royle), 21 (Feb)

An experimental study to evaluate the effectiveness of a diabetic teaching tool, (Skelton), (abst), 48 (Sep)

A multidimensional analysis of role perception in a mental health system, (Riddell), (abst), 48 (Sep)

Nursing research in Alberta: a beginning descriptive study, (Simms), (abst), 50 (Feb)

Professionalism in nursing, (Valentine), (abst), 50 (Oct)

Special committee on research continued by CNA directors, 5 (Jun)

Staff nurse involvement in research — myth or reality? (Stinson), 28 (Jun)

A study of the attitudes of public health nurses as they affect the teaching of family planning, (McEwan), (abst), 48 (Sep)

A study to develop instruments to evaluate the effectiveness of a post-diploma program in nursing, (Rivett), (abst), 52 (Feb), 50 (Apr)

A survey of Canadian schools of nursing to determine the instruction and clinical

experience provided in mental retardation, (Pearen), (abst), 50 (Oct)

A survey to determine the perceptions of a selected group of head nurses and supervisors concerning the channels of communication existing within a hospital, (Hoeffler), (abst), 50 (Apr)

Ten tips on preparing research proposals, (Spitzer), 30 (Mar)

#### RESEARCH ABSTRACTS

50 (Feb), 50 (Mar), 50 (Apr), 48 (Sep), 50 (Oct)

#### RESPIRATION

Auscultation of the chest—a clinical nursing skill, (Slessor), 40 (Apr)

#### REUTTER, Linda Isabel

Faculty U. of Alberta school of nursing, 43 (Dec)

#### REYNAUD, André

Guess who's coming to lunch? (port), 7 (Nov)

## REYNOLDS, Jeanne

Dean of faculty of nursing of University of Montreal, (port), 46 (Sep)

#### RICHARDSON, Lenna

Honored at retirement, (port), 41 (Dec)

#### RIDDELL, Beverley J.

A multidimensional analysis of role perception in a mental health system, (abst), 48 (Sep)

#### RIDLEY, Una L.

Vice-president of Council of College of Nurses of Ontario, 26 (Oct)

## RILEY, Irma K.

Bk. rev., 43 (Jul)

#### RISK, Margaret

Assistant director of nursing at Borough of East York Health Unit, 43 (Dec)

#### RIVETT, Roberta Edith

Assistant director University Hospital, London, Ont., (port), 49 (Apr)

A study to develop instruments to evaluate the effectiveness of a post-diploma program in nursing, (abst), 52 (Feb) 50 (Apr)

#### ROBBINS, Harold

Bk. rev., 49 (Jan)

#### ROBBINS, Larry

Employment relations dept. RNAO, 41 (Dec)

## ROBERTS, Pamela M.

Bk. rev., 42 (Aug)

## ROBINSON, Phyllis M.

Director of nursing education, Calgary General Hospital school of nursing, 43 (Dec)

#### ROBINSON, Suzanne M.

Mildred I. Walker Bursary Fund award, 17 (Jul)

#### ROSEN, David A.

Argon laser photocoagulation for retinal vascular disease, 36 (May)

#### ROSKY, Allan

Associate employment relations adviser of MARN, 41 (Dec)

### ROSS, Carole

Assistant director of nursing, children's services, Douglas Hospital, Verdun, P.Q., (port), 47 (May)

#### ROTHWELL, Sue

Bk. rev., 54 (Oct)

#### ROUSSEAU, Chantal

CNF scholarship, 12 (Sep)

## ROWAT, Kathleen M.

Bk. rev., 42 (Jul)

#### ROWSON, Lorraine G.J.

Curriculum coordinator at Lakehead Regional School of Nursing, Thunder Bay, Ont., (port), 49 (Mar)

## ROYAL CANADIAN ARMY MEDICAL CORPS

Bursary open to nurses, 16 (May)

## ROYAL COLLEFE OF PHYSICIANS AND SURGEONS

Basic health care changes needed nurse tells physicians' meeting, 7 (Nov)

#### ROYAL SOCIETY OF HEALTH

Joyce Nevitt fellow, (port), 47 (Mar)

## ROYLE, Joan

Bk. rev., 50 (Dec)

Coronary patients and their families receive incomplete care, 21 (Feb)

Staff at McMaster University School of Nursing, 47 (Jan)

#### RUITERMAN, Trudi

Street nurses in blue jeans, (Biette), 34 (Jan)

#### RUNDLE, Gladys

Health care at Toronto International Airport, (port), (Starr), 32 (Feb)

#### RYCHTELSKA, Maria

Nurse adviser at ICN in Geneva, 16 (Jul)

S

## SAFETY

If you drive a car, 46 (Feb)

#### ST. FRANCIS XAVIER UNIVERSITY

University schools of nursing in Canada, 23 (Jan)

#### ST. JOHN AMBULANCE

B.C. senior citizens receive instruction in home nursing, 7 (Nov)

Editorial, (Lockeberg), 3 (Sep)

Health care at Toronto International Airport, (Starr), 32 (Feb)

Yvette Loiselle superintendent-in-chief, (port), 47 (Mar)

#### SALARIES

CNA and provincial associations support federally employed nurses who protest salaries below peers, 7 (Dec)

Nurses in Great Britain protest proposed salaries in national health service, 15 (Oct)

Pay for nurse in expanded role should be salary, not fee: CNA, 11 (Mar)

#### SANDI, Emil

Trace elements in food, (Clegg), 38 (Feb)

## SASKATCHEWAN HOSPITAL ASSOCIATION

SRNA, SMA, SHA conference supports joint health planning, 17 (Jun)

## SASKATCHEWAN MEDICAL ASSOCIATION

SRNA, SMA, SHA conference supports joint health planning, 17 (Jun)

## SASKATCHEWAN REGISTERED NURSES' ASSOCIATION

SRNA, SMA, SHA conference supports joint health planning, 17 (Jun)

Bursaries awarded, 47 (Mar)

Correction, 8 (Oct)

Council elected, 44 (Sep)

Ends all involvement in collective bargaining after Supreme Court ruling, 12 (Dec)

Exec. secretary summonsed before labor relations board, 12 (Jan)

Five Saskatchewan nurses honored, (port), 44 (Sep)

Margaret Wakeling appointed consumer representative, 43 (Jun)

Nurses will be most affected by community health centers professor tells SRNA meeting. 12 (Aug)

Sask, labor relations board told to rehear nurses' application, 16 (Jun)

Speaker at SRNA meeting focuses on women's work problems, 7 (Sep)

Welcomes provincial plan to set up family planning program, 9 (Sep)

## SAUNDERS, Peggy

Assistant professor at UBC, (port), 49 (Mar)

Bk. rev., 53 (Sep) Bk. rev., 48 (Dec)

#### SAVOIE, Shirley

Director of nursing services, Shuswap Lake General Hospital, Salmon Arm, B.C., 24 (Oct)

#### SAYERS, Allison

Staff at Queen's University school of nursing, 42 (Dec)

#### SCHAFFER, Elaine

Do-it-yourself dialysis, 29 (Jul)

#### SCHENKEL, Brenda

District nurse for Ontario Society for Crippled Children, London, Ont., 49 (Apr)

#### SCHILLING, Karin von

Bk. rev., 52 (Apr)

#### SCHOLARSHIPS AND BURSARIES

NBARN announces awards, 42 (Dec) RCAMC bursary open to nurses, 16 (May) SRNA bursaries awarded, 47 (Mar)

Antoinette Bourgeois awarded NBARN scholarship, 44 (Jun)

Beverley M. McCann received bursary from Ontario division of Volunteer Nursing Service Committee of the Canadian Red Cross Society, 36 (Nov)

Elizabeth Lorraine Holder awarded Volunteer Nursing Services Bursary from the Canadian Red Cross Society, 47 (Mar)

How CNF scholars are selected, (Henderson, Archibald), 33 (May)

Jo-Ann Tippett Fox awarded Medical Research Council studentship, 26 (Oct)

Mildred I. Walker Bursary Fund awards for 1972-73, 17 (Jul)

Ont. Red Cross Society offers bursary to nurses, 16 (Dec)

Regina General Nurses' Alumnae offers graduates \$500 scholarship, 17 (Jun)

\$31,500 in CNF scholarships awarded to 10 Canadian nurses, 12 (Sep)

#### SCHOOL HEALTH

CNA executive approves responses to school health recommendations, 7 (Feb) Nurses, smoking, and schoolchildren, (Wake et al), 19 (Jul)

## SCOLLIE, June R.

Bk. rev., 54 (Sep)

### SCORER, Pat

Staff Health Sciences Centre, Winnipeg, (port), 24 (Oct)

#### SCOTT-WRIGHT, Margaret

Second vice-president ICN, 16 (Jul)

#### SCHUMACHER, Marguerite E.

CNA honors Jean Leask on her retirement, (port), 46 (Mar)

Message from President of the Canadian Nurses' Association, (guest edit), 3 (Mar)

#### **SELYE, Hans**

Work is a basic biologic need Selye tells fitness conference, 10 (Feb)

### SERVICE EMPLOYEES

#### INTERNATIONAL UNION

SRNA Exec. secretary summonsed before labor relations board, 12 (Jan)

#### SETTER, Doris

Staff Health Sciences Centre, Winnipeg. (port), 24 (Oct)

## SHAW, Ann Dorothy

Public relations officer AARN, (port), 36 (Nov)

#### SHEA, Hattie Lee

Bk. rev., 56 (Sep)

## SHIRAISHI, Florence Sachi

Educational consultant for Toronto Dept. of Public Health, (port), 48 (Apr)

#### SIAMESE TWINS

Surgical separation of conjoined twins, (Dirksen, Meilicke), 26 (May)

#### SIKORA, Frances

Nurse director of Canadian Mothercraft Society, Ottawa branch, 24 (Oct)

#### SIMARD, Noella

NBARN scholarship, 42 (Dec)

## SIMINOVITCH, Louis

Genetic manipulation: now is the time to consider controls, 30 (Nov)

#### SIMMS, Ada Elizabeth

Nursing research in Alberta: a beginning descriptive study, (abst), 50 (Feb)

#### SIMMS, Laura L

Spotlight on the clinical nurse specialist, (Dworkin), 40 (Sep)

## SKELTON, Judith M.

A diabetic teaching tool, 35 (Dec)

An experimental study to evaluate the effectiveness of a diabetic teaching tool, (abst), 48 (Sep)

#### SKIN

Decubitus ulcer management — a team approach, (Morley), 41 (Oct)

#### SLESSOR, Gail

Auscultation of the chest — a clinical nursing skill, 40 (Apr)

#### SMALL, Muriel E.

N.S. government appoints nurse to health services commission, 12 (Nov)

Appointed to Health Services Commission of Nova Scotia, (port), 36 (Nov)

#### SMITH, Janet Hersberger

Faculty U. of Alberta school of nursing, 43 (Dec)

#### SMITH, Laura

Staff of North Okanagan Mental Health Centre, Vernon, B.C., 42 (Dec)

#### SMITH, Margaret

Honoured by Middlesex-London District Health Unit, (port), 45 (Sep)

#### SMOKING

CNA directors at work..., 17 (Mar), 11 (Jun)

CNA policy statement on smoking, 15 (Jun)

NBARN invited to be represented on N.B. Council on Smoking, 12 (Oct)

The case of the tobacco leaves, (Lindabury), (edit), 3 (Nov)

Cigarettes butted, ashtrays gone and CNA board meeting ends early, 8 (Dec)

Law against smoking? 48 (Oct)

Nurses, smoking, and schoolchildren, (Wake et al), 19 (Jul)

Smoking now and then, (Garrett), 22 (Nov)

## SNYDER, Caroline

Spotlight on the clinical nurse specialist, (Dworkin), 40 (Sep)

#### SOCIETIES

CNA directors at work..., 17 (Mar), 11 (Jun)

Freedom: an outmoded tradition, (Gilchrist), 25 (Apr)

Keynote speaker at ARNN meeting has advice for associations, 8 (Nov)

## SOCIETIES, NURSING

CNA directors at work ... 11 (Jun)
Editorial, (Lockeberg), 3 (Sep)
Founding meeting of Canadian Council
of Cardiovascular Nurses, 18 (May)
Professionalism in nursing, (Valentine),

(abst) 50 (Oct)

## SOUTH AFRICAN NURSING ASSOCIATION

Must try to change law by '75: ICN, 7 (Jul)

## SPARKES, David G.

Employment relations officer ARNN, (port), 43 (Jun)

SPARKS, F.L. (Nan) Bk. rev., 54 (Sep)

## SPECIALTIES, NURSING

CNA directors at work..., 17 (Mar), 11 (Jun)

CNA statement on specialization in nursing, 11 (Dec)

Spotlight on the clinical nurse specialist, (Dworkin), 40 (Sep)

## SPITZER, Walter O.

Changing nursing practice through education, (et al), 28 (Apr)

Ten tips on preparing research proposals, 30 (Mar)

## SPLANE, Verna Huffman

Third vice-president ICN, (port), 16 (Jul)

#### SPRY, Mary

Assistant director of nursing at Oshawa General Hospital, 17 (Jul)

#### STACKHOUSE, Joan

Myasthenia gravis, 28 (Dec)

#### STANKO, Barbara

Crisis intervention after the birth of a defective child, 27 (Jul)

## STARR, Dorothy S.

ICN meets in Mexico, 17 (Aug)

Health care at Toronto International Airport, 32 (Feb)

International Council of Nurses, Congress 1973, (edit), 3 (Aug)

#### STEELS, Marilyn Margar et

Bk. rev., 48 (May)

Perceptual style and the adaptation of the aged to the hospital environment, (abst), 50 (Mar)

Staff at McMaster University School of Nursing, 47 (Jan)

## STEPHENSON, Bette M.

President CMA, 44 (Sep)

#### STERILIZATION

Laparoscopy, (Beardall), 34 (Apr)
Needed: a change in attitudes toward elective sterilization, (Fortier), 21 (Jan)
Weekend program for tubal ligation, (Gardner), 37 (Apr)

#### STEVENS, Grace

Life membership in NBARN, 16 (Jul)
Retired as associate employment relations
officer for New Brunswick Nurses Provincial Collective Bargaining Councils,
45 (Jan)

## STEWART, Mary C.

Bk. rev., 49 (Dec)

#### STEWART, Norma June

CNF scholarship, 12 (Sep)

#### STIANSEN, Bernice

Staff at Grant MacEwan Community College, (port), 46 (Jan)

#### STINSON, Shirley M.

Graduate program coordinator for U. of Alberta School of Nursing, 24 (Oct) Staff nurse involvement in research—

#### STRANG, Victoria

Clinical assistant at Lakehead University, 49 (Mar)

#### STROBBE, Lorine

SRNA bursary, 48 (Mar)

myth or reality? 28 (Jun)

#### STUDENTS

Executive director emphasizes student participation in ICN, 14 (Mar)

Neuro nurses sponsor contest for student nurses in Canada, 14 (Jan)

The nurse in a student physician's "practice," (Valberg), 17 (Nov)

Student nurses share in clinical learning, (Corbett), 21 (Nov)

## STYRAN, Patricia

Bk. rev., 52 (Mar)

#### SURGERY

Cardiac surgery in the first person, (Guthrie), 31 (Sep)

Surgical separation of conjoined twins, (Dirksen, Meilicke), 26 (May)

#### SURGICAL NURSING

Cardiac surgery in the first person, (Guthrie), 31 (Sep)

Surgical separation of conjoined twins, (Dirksen, Meilicke), 26 (May)

#### SUTHERLAND, William

With MEDICO, (port), 47 (May)

## SUTHERLAND, Winifred McLean

With MEDICO, (port), 47 (May)

T

#### TARDIVELLE, Merren

Editor of International Nursing Review, (port), 46 (Mar)

#### TAYLOR, Elizabeth Ann

Director of nursing for East York Health Unit, Toronto, 48 (Apr)

#### TEACHING

A diabetic teaching tool, (Skelton), 35 (Dec)

The effects of error modeling on the learning of a complex procedure in nursing, (Parker), (abst), 50 (Feb)

A study of the attitudes of public health nurses as they affect the teaching of family planning, (McEwan), (abst), 48 (Sep)

### TENBRINK-HO, Carole

Bk. rev., 46 (Jun)

### TEWARI, Pansy

Bk. rev., 43 (Aug)

## **THERMOMETERS**

Glass is the culprit, 39 (Jul)

## THOMAS, Eleanor

Nurses, smoking, and schoolchildren, (et al), 19 (Jul)

#### THOMPSON, Audrey

Chosen nurse of the year by AARN, (port), 38 (Aug)

#### THOMPSON, Raymond M.

Assistant professor at UBC School of Nursing, (port), 49 (Mar) Bk. rev., 47 (Jun)

#### THOMPSON, Sylvia

Director of nursing, Mills Memorial Hospital, Terrace, B.C., 43 (Dec)

#### THOMSON, Jean E. Browne

Obit, 41 (Dec)

#### TOOLEY, Judy L.

SRNA bursary, 47 (Mar)

#### TORONTO INTERNATIONAL AIRPORT

Health care at Toronto International Airport, (Starr), 32 (Feb)

#### TOWER, Yvonne

Employment relations dept. RNAO, 41 (Dec)

#### TRAVEL

Health care at Toronto International Airport, (Starr), 32 (Feb)
Precautions for travelers, 37 (Sep)
Travelers warned, 40 (Dec)

#### TROPICAL MEDICINE

New tropical medicine group invites nurses' membership, 18 (Mar) Pregautions for travelers, 37 (Sep) Tropical and parasitic diseases: new challenge to health teams, (Lenczner), 34 (Sep)

### TROUT, Ferne

Nurse consultant with CCHA, (port), 26 (Oct)

#### TRUDEAU, Pierre Elliott

Guess who's coming to lunch? (port), 7 (Nov)

## TUBERCULOSIS

ETIBI tablets, 22 (Apr)

#### TUDOR, Donna

With Ontario Society for Crippled Children, Mississauga office, (port), 44 (Jun)

## U

#### UJHELY, Gertrud B.

The patient as an equal partner, 21 (Jun)

## **UNIFORMS**

Nurses model latest fashion, 16 (May) Wanted: student uniforms, 18 (Mar)

#### UNIVERSITY OF ALBERTA

Faculty appointments at school of nursing, 43 (Dec)

Shirley M. Stinson graduate program coordinator, 24 (Oct)

University schools of nursing in Canada, 23 (Jan)

## UNIVERSITY OF BRITISH COLUMBIA

Edith Vivian Benoit appointed assistant professor, (port), 46 (Jan)
Monica D. Angus received 1972 Alice E.

Wilson Award and elected to Senate, (port), 48 (Feb)

Muriel Uprichard and Alice J. Baumgart ~elected to senate, 48 (Mar)

Peggy Saunders assistant professor, (port), 49 (Mar)

Raymond M. Thompson assistant professor, (port), 49 (Mar)

Sylvia Diane Paulson assistant professor, 36 (Nov)

University schools of nursing in Canada, 23 (Jan)

#### UNIVERSITY OF CALGARY

Faculty appointments, (port), 47 (May) University schools of nursing in Canada, 23 (Jan)

## UNIVERSITY OF MANITOBA

University schools of nursing in Canada, 23 (Jan)

#### UNIVERSITY OF MONCTON

University schools of nursing in Canada, 23 (Jan)

#### UNIVERSITY OF MONTREAL

Jeanne Reynolds dean, (port), 46 (Sep) University schools of nursing in Canada, 23 (Jan)

## UNIVERSITY OF NEW BRUNSWICK

Lois E. Graham dean, (port), 45 (Sep) University schools of nursing in Canada, 23 (Jan)

#### UNIVERSITY OF OTTAWA

University schools of nursing in Canada, 23 (Jan)

#### UNIVERSITY OF SASKATCHEWAN

Becomes professional college, 15 (Aug) University schools of nursing in Canada, 23 (Jan)

#### UNIVERSITY OF TORONTO

University schools of nursing in Canada, 23 (Jan)

#### UNIVERSITY OF WESTERN ONTARIO

M. Josephine Flaherty dean, (port), 48 (Feb)

University schools of nursing in Canada, 23 (Jan)

## UNIVERSITY OF WINDSOR

University schools of nursing in Canada, 23 (Jan)

#### **UPRICHARD**, Muriel

Elected to senate of UBC, 48 (Mar)

#### V

## VALBERG, Barbara

The nurse in a student physician's "practice," 17 (Nov)

#### VALENTINE, Patricia Ellen B.

Professionalism in nursing, (abst), 50 (Oct)

#### VALERIOTE, Patricia

Director of patient services, St. Joseph's Hospital, Guelph, (port), 43 (Dec)

## VARGHESE, Aleyamma

Bk. rev., 43 (Jul)

#### VENEREAL DISEASE

World-wide gonorrhea problem brings researchers together, 15 (Dec)

## VICTORIA HOSPITAL, CASTRIES, SAINT LUCIA, WEST INDIES

West Indian nurses enjoy Canadian nursing books, 8 (Feb)

#### VICTORIAN ORDER OF NURSES

CNA honors Jean Leask on her retirement, (port), 46 (Mar)

Ada McEwan national director, (port), 46 (Mar)

Coordinates health care for seniors, (Prime), 44 (Feb)

Editorial, (Lockeberg), 3 (Sep)

Esther Janzow district director, 26 (Oct)

## VISSCHER, Wilhelmina (Willy)

Retired, (port), 43 (Jun)

## W

#### WAKE, F.R.

Nurses, smoking, and schoolchildren, (et al), 19 (Jul)

#### WAKELING, Margaret

Consumer representative on council of SRNA, 43 (Jun)

## WALLINGTON, Marjorie A.

Assistant professor at Lakehead University, 48 (Mar)
Bk. rev., 46 (Jun)

#### WALSH, Edna

Director of public health nursing, Nova Scotia dept. of public health, (port), 48 (Apr)

## WALSH, William

RNAO school teaches nurses collective bargaining techniques, 7 (Sep)

#### WARE, Mary Lou

Staff at McMaster University School of Nursing, 47 (Jan)

#### WATSON, Ina

Bk. rev., 41 (Jul)

#### WEBB, M. (Peggy) R.

Faculty University of Calgary, School of Nursing, (port), 47 (May)

#### WEINSTEIN, Morene Gavle

Students on a curriculum revision committee, 38 (Mar)

WEIR, Jennie M.

Bk. rev., 51 (Mar)

#### WENCK, Lieselotte

Health care at Toronto International Airport, (port), (Starr), 32 (Feb)

#### WENDRIL, Marion

Pegboard as space saver, 43 (Feb)

#### WHITE, Hazel

Retired, 43 (Dec)

#### WILLET, Mary Barbara

Consultant in school nursing for Toronto Dept. of Public Health, (port), 48 (Apr)

#### WILLIAMS, Marguerite C.

Nursing consultant for Toronto Dept. of Public Health, (port), 48 (Apr)

#### WILLS, Joan Ann

Director of public health nursing of Leeds, Grenville, Lanark District Health Unit, (port), 44 (Jun)

## WILSON, E. Susan

Charge nurse in family planning for Edmonton local board of health, 43 (Dec)

#### WILTING, Jennie

Staff at Grant MacEwan Community College, (port), 46 (Jan)

#### WINNIPEG GENERAL HOSPITAL

AV equipment donated to Winnipeg School of Nursing, 45 (Jun)

Patients' recreational program, (McLellan), 37 (Mar)

Students on a curriculum revision committee, (Weinstein), 38 (Mar)

#### WOLFE, Bernard M.

Hypoglycemia, (Powers), 38 (Oct)

#### WOMEN

Poor women's rights, 40 (Aug)

## WOMEN — EMPLOYMENT

Correction, 8 (Oct)

Speaker at SRNA meeting focuses on women's work problems, 7 (Sep)

### WOOD, D.

Bk. rev., 42 (Jul)

#### WOODARD, Leah Ann

SRNA bursary, 48 (Mar)

## WORLD FEDERATION OF NEUROSURGICAL NURSES

Plan 1973 meeting, 14 (Mar)

#### WORLD HEALTH ORGANIZATION

Health care at Toronto International Airport, (Starr), 32 (Feb)

World-wide hypertension is hidden epidemic — WHO, 20 (Apr)

## WYATT, Dorothy

On city council of St. John's Nfld., 17 (Jul)

## WYLIE, Dorothy

Assistant executive director Sunnybrook Hospital, (port), 17 (Jul)

#### WYLIE, Norma

Start from where you are directors of nursing told, 12 (Jul)

X

Y

#### YOSHIDA, May A.

Changing nursing practice through education, (et al), 28 (Apr)

Staff at McMaster University School of Nursing, 47 (Jan)

#### YOUNG, Norma

Staff at Grant MacEwan Community College, (port), 45 (Jan)

Z

#### ZAGRODNEY, Lola

Staff at Queen's University school of nursing, 42 (Dec)

#### **ZELMER, Amy Elliott**

Faculty U. of Alberta school of nursing, 43 (Dec)



# Library and Archives, CNA House



## PROVINCIAL ASSOCIATIONS OF REGISTERED NURSES

#### Alberta

Alberta Association of Registered Nurses, 10256 - 112 Street, Edmonton. T5K 1M6. Pres.: A.J. Prowse; Pres.-Elect: D.E. Huffman; Vice-Pres.: A. Thompson, I. Walker. Committees - Staff Nurses: C. Asp; Nsg. Educ.: W. Mills; Nsg. Practice: A. Clark; Superv. Nurses: J. Smith; Project Direc. Nsg. Educ.: M. Moncrieff. Prov. Office Staff-Pub. Rel. Officer: A. Shaw; Employ. Rel .: Y. Chapman; Asst. Employ. Rel. Officer: R.R. Donahue; Nsg. Serv. Consult.: B. Sellers; Comm. Advisor: H. Cotter; Registrar: A.R. McKinnon; Exec. Sec.: H.M. Sabin; Office Manager: M. Garrick.

## **British Columbia**

Registered Nurses' Association of British Columbia, 2130 West 12th Avenue, Vancouver. Pres.: G. LaPointe; Vice-Pres.: T. Duck, R. Macfadyen. Committees - Nsg. Educ.: J.K. Griffith; Nsg. Practice: E.H. Dancer; Soc. & Econ. Welf .: B. Archer. Staff - Exec. Direc.: F.A. Kennedy; Registrar: H. Grice; Asst. Registrar: J. Small; Direc. Educ. Serv.: C. Kermacks; Asst. Direc. Educ. Serv.: J. McCullagh; Direc. Nsg. Serv.: T. Schnurr; Direc. Personnel Serv.: N. Paton; Asst. Direc. Personnel Serv.: (Placement Serv.): F. MacDonald, (Labor Rel.): G. Smale; Direc. Comm. Serv.: C. Marcus; Librarian: J. Molson; Admin. Asst.: D. St. Germain.

#### Manitoba

Manitoba Association of Registered Nurses, 647 Broadway Avenue, Winnipeg. R3C 0X2. Pres.: F. McNaught; Past Pres.: E.M. Nugent; Vice-Pres.: R.G. Black, L. McClure. Committees - Nsg.: A. Croteau, M. Swedish; Soc. & Econ. Welf .: A. Daniels; Legisl .: O. McDermott; Brd. of Exam.: O. McDermott; Finance: K. DeJong; Profess. Staff-Employ. Rel. Advis.: J. Gleason; Pub. Rel. Officer: M. Paynter; Registrar: M. Caldwell; Contin. Educ. Advis.: H. Sundstrom.

### **New Brunswick**

New Brunswick Association of Registered Nurses, 231 Saunders Street, Fredericton. Pres.: B. LeBlanc; Past Pres.: A. Robichaud; Vice-Pres.: S. Cormier, R. Dennison; Hon. Sec.: S. Robichaud. Committees - Nsg.: Z. Hawkes, S. MacLeod; Nsg. Asst. Comm.: J. Sherwood; Legisl.: K. Wright; Exec. Sec.: M.J. Anderson; Liaison Officer: N. Rideout; Consult. Soc. & Econ. Welf.: G. Rowsell; Registrar: E. O'Connor; Asst. Exec. Sec. & Registrar: M. Russell; Ednc. Consult: A. Christie,

#### Newfoundland

Association of Registered Nurses of Newfoundland, 67 Le Marchand Road, St. John's. Pres.: E. Wilton; Past Pres.: P. Barrett; Pres. Elect: F. Bouzan; Vice-Pres.: E. Summers, J. Nevitt. Committees - Nsg. Educ.: E.

Gardner; Nsg. Serv.: J. Pawlett; Soc. & Econ. Welf.: W. Williams; Exec. Sec.: P. Barrett.

#### Nova Scotia

Registered Nurses' Association of Nova Scotia, 6035 Coburg Road, Halifax. Pres.: M. Bradley; Past Pres.: J. Fox; Vice-

Pres.: Sr. M. Barbara, G. Smith, C. Butler: Record. Sec.: Sr. M. Gillis; Exec. Sec.: F. Moss. Committees - Nsg. Educ.: T. Blaikie: Nsg. Serv.: S. MacDonald; Soc. & Econ. Welf.: G. Murphy; Advis. Nsg. Educ.: Sr. C. Marie; Advis. Nsg. Serv.: J. MacLean; Employ. Rel. Officer: M. Bentley; Pub. Rel. Officer; D. Miller: Admin. Asst.: E. MacDonald.

#### Ontario

Registered Nurses' Association of Ontario, 33 Price Street, Toronto, M4W 1Z2. Pres.; W.J. Gerhard; Pres. Elect; N.M. Marossi. Committees - Socio-Econ. Welf.: C.J. Seppala; Nsg.: G.L. Schmidt; Educator: C.J. Faulkner; Admin.: M.L. Peart; Exec. Direc.: L. Barr; Asst. Exec. Direc.: D. Gibney; Direc. Employ. Rel.: A.S. Gribben; Direc. Profess. Devel.: C.M. Adams; Reg. Exec. Sec.: M.I. Thomas, F. Winchester.

### **Prince Edward Island**

Association of Nurses of Prince Edward Island, 188 Prince St., Charlottetown,

Pres.: E. MacLeod; Past Pres.: C. Carruthers; Pres. Elect: B. Robinson; Vice Pres.: S. Mulligan; Exec. Sec.-Reg.: L. Fraser. Committees - Nsg. Educ.: D. Sawler; Nsg. Serv.: J. Peters; Pub. Rel.: H. Wood; Finance: C. Carruthers; Legisl. & Bv-Laws: Sr. M. Cahill; Soc. & Econ. Welf.: M. Babineau.

### Quebec

Association of Nurses of the Province of Quebec, 4200 Dorchester Blvd., W., Montreal, H3A IV2.

Pres.: R. Bureau; Vice-Pres.: S. O'Neill, G. Lennox (Eng.), J. Tellier-Cormier, E. Foy-Drolet (Fr.); Hon. Treas.: Sr. P. Lecours; Hon. Sec.: R. Dansereau. Committees - Nsg. Educ.: G. Allen, D. Lalancette; Nsg. Serv.: J. Hackwell, R. Dionne; Profess. Serv.: S. O'Neill, P. Murphy; School of Nsg.: R. Atto, C. de Villiers Sauvé; Legisl.: M. Masters, C. Bélanger; Sec. Reg.: N. Du Mouchel; Pub. Rel. Officer: M. Jean.

#### Saskatchewan

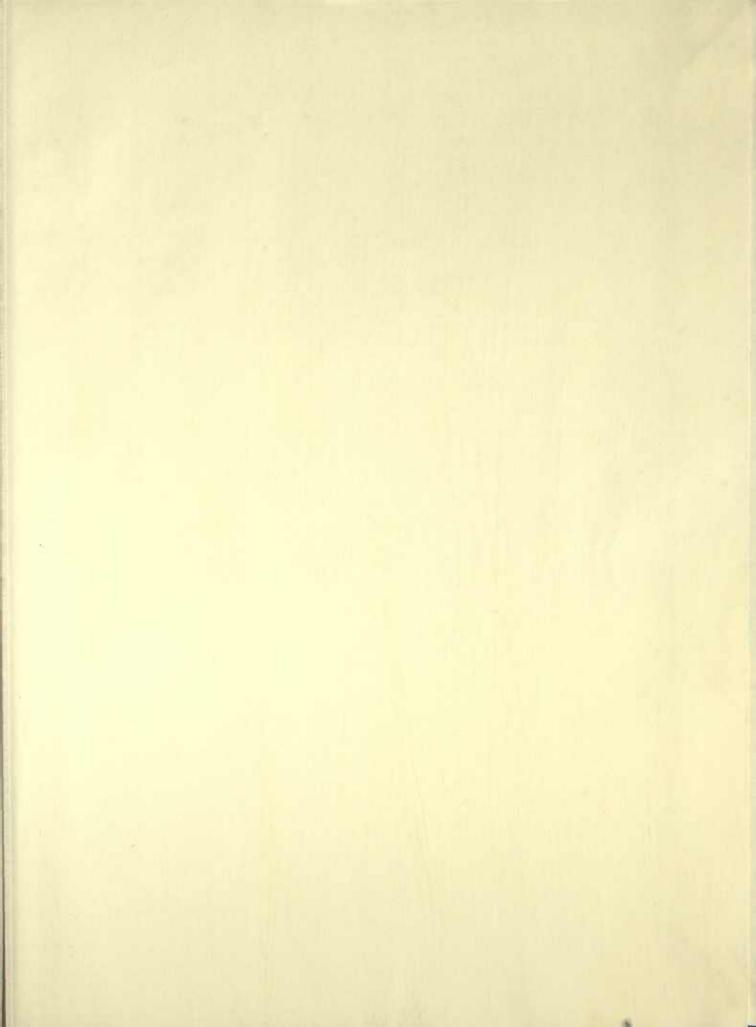
Saskatchewan Registered Nurses' Association, 2066 Retallack St., Regina. S4T 2K2. Pres.: D.J. Pipher; Past Pres.: E. Linnell; Pres. Elect: J. MacKay; Vice-Pres.: Sr. B. Bezaire, S. Rhoden. Committees - Nsg.: 1. Watson; Chapters & Pub. Rel.: R. Ledingham; Soc. & Econ. Welf.: G. Hutchinson: Exec. Sec.: A. Mills; Registrar: E. Dumas; Pub. Inform. Officer: B. Schill; Nsg. Consult.: R. Mireau; Asst. Registrar: J. Passmore.

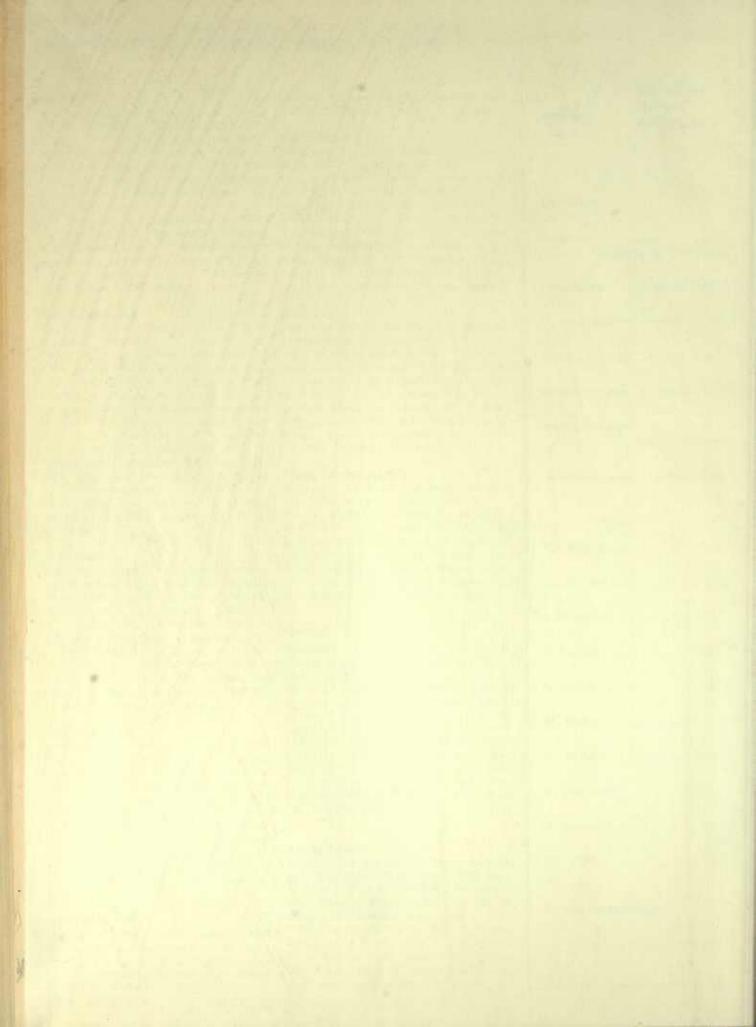


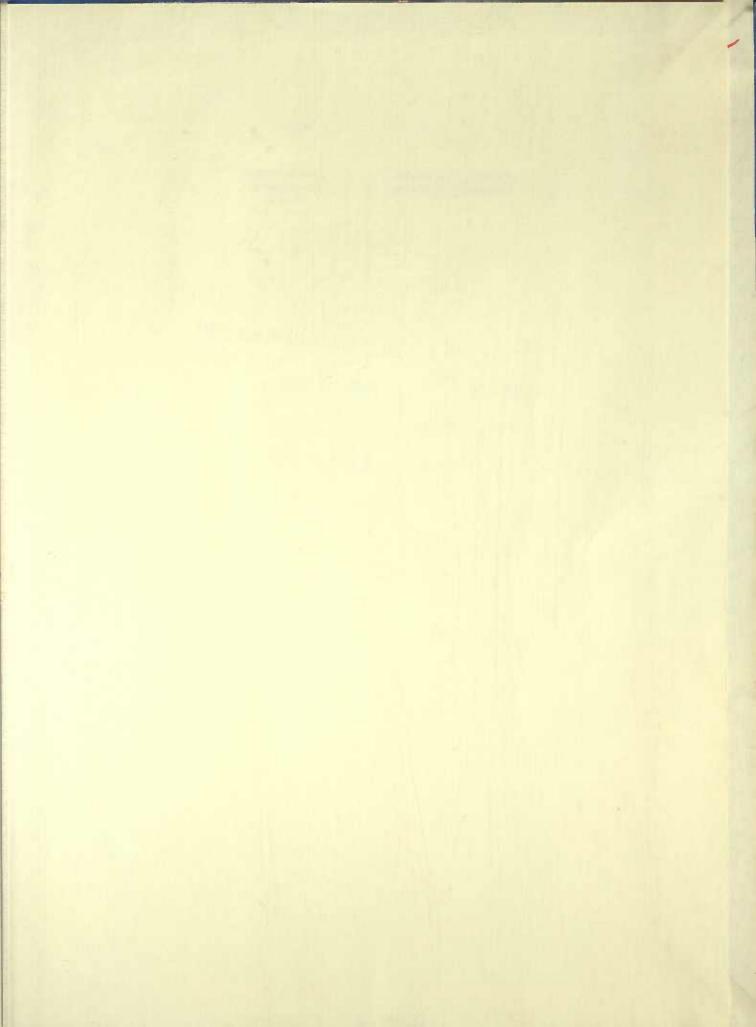
## Canadian Nurses' Association

## **Directors**

President
President-Elect Huguette Labelle
1st Vice-President Beverly Du Gas
Member-at-Large Glenna Rowsell
Member-at-Large K. Marion Smith
Member-at-Large
Member-at-Large, Roberta Coutts
A.J. Prowse AARN
G. LaPointeRNABC
F. McNaught MARN
B. LeBlancNBARN
E. Wilton ARNN
M. BradleyRNANS
W. Gerhard RNAO
E. MacLeod ANPEI
R. Bureau ANPQ
DJ. Pipher SRNA
Executive Director
LACCULIVE DIRECTOR







## BIBLIOTHÈQUE VANIER UNIVERSITÉ D'OTTAWA Échéance

Celui qui rapporte un volume après la dernière date timbrée ci-dessaus, devra payer une amende de 10 cents, plus 5 cents pour chaque jour de retard.

## VANIER LIBRARY UNIVERSITY OF OTTAWA Date due

Far failure to return a baak on or befare the lost date stamped below there will be a fine of 10 cents, and an extra charge of 5 cents far each additional day.

JUL 3 0 1982 JUL 2 7 1982 FEB 2 6 1983	DEC 0 1 1986 8 FEV. 1991 0 1 MARS 1991 MAR 1 8 1987 MAR 1 8 1987
22-2-84. FEB 2 1 1984	JUL 27 1987
19-4-84.  APR 18 1984  DEC 0 1 1986  SS02-BV03-30M-79/7	2 9 MAT 1998

